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TEACHING MENTAL HYGIENE: A PROBLEM IN RESISTANCES

BY AVRAAM T. KAZAN, M. D., ELLEN K. OSTROW, M. S. S.,
RUTH CUMINGS, M. A., AND MILTON V. KLINE, Ed.D.

One of the most urgent health and social needs of our day is for methods whereby established principles of mental hygiene can be put into progressively broader application. Such a method is gradually being evolved as public health and mental hygiene conjointly direct their attention and energies toward the solution of this problem. Lemkau,[1] Ginsberg,[2] Zimmerman,[3] and Spock[4] have been among those who have made practical and theoretical contributions to public health mental hygiene. It is indicated, however, that all groups actively engaged in such work share their experiences so that each new venture into this little-known territory can begin at a point in advance of previous ones. The purpose of this paper is to describe the experience of one community in the systematic application of mental hygiene principles through the medium of public health nurses.

The work has been in progress within the structure of the Westchester County Department of Health since September 1948. The plan has been simple: to teach the principles and practice of mental hygiene to a large group of public health nurses so that they in turn can utilize and teach this knowledge in their daily work with patients in the home, in the school, and in the clinic. Since the public health nurses taking part in this program make approximately 180,000 professional contacts a year, the importance for the community's mental health of such an indoctrination could be tremendous.

Setting and Organization of Project

The project was carried out in suburban Westchester County, which borders New York City on the north. It is a community whose health, social welfare, and psychological resources are exceptionally numerous and well-organized. The Westchester County Department of Health, through its division of mental hygiene, established a teaching liaison with the public health nurses of the county —this liaison being effected primarily by two mental health consultants with highly specialized but quite different training and experience. They carried on an intensive in-service training program of mental health education with the nurses, the program extending in its initial phase over a two-year spread of time.

All told, a public health nursing corps* of about 164 nurses (about 127 staff nurses, 20 student nurses, 11 supervisors, and six directors of nursing) was involved. Represented were nine different nursing offices varying in size from eight to 25 member nurses. All personnel did not participate for the entire duration of the work, but all were included for a minimum of two months, and well over 100 nurses worked for a year or more with the consultants. The average amount of consultant's time specifically allotted to each of the nine nursing offices was about two days a month.

The first consultant** to join the staff (October 1949) was a psychiatric social worker with extensive experience in social agency settings and considerable background in analytically-oriented case work treatment. Since this was her first contact with public health work, a three-month orientation period in a public health setting was arranged. The second consultant joined the staff six months later (April 1950). She was a public health nurse with seven years experience as a staff nurse and an additional year in teaching and supervisory nursing activity. Two years before joining the project, this nurse had been sent from the health department staff to attend the course for public health nurse mental health consultant given at Teachers College of Columbia University.

Development of Program

As might be expected, the mental hygiene education of the public health nurses of Westchester County went back many years before the present work was begun; but this education was sporadic and unsystematized. For at least 10 years prior to the inauguration of the program described here, the majority of public health nurses of Westchester County had expressed a keen interest in mental health. It was this interest which had sparked the County Health Department in sending a nurse appropriately qualified in personality and experience to Columbia for training. It was the same interest, working from a slightly different vantage point, which led the Mental Hygiene Association of the county to offer the funds for a psychiatric social work consultant.

*In this report both public health and visiting nurses will be included under the term "public health nurses."

**The salary for this consultant was provided for the county health department on a two-year demonstration basis by a grant from the Mental Hygiene Association of Westchester County.

As "basic training" for the program, a series of 10 general orientation lectures was given for the nurses by persons representing the specialties of psychiatry, social work, psychology, and nurse mental health consultant. As a further exploratory step, the director of the division of mental hygiene held a series of 15 clinical conferences with the nurses of one of the larger nursing offices. Since the response to this work was enthusiastic, it was agreed by common consent of the staffs involved that in the succeeding year more intensive work in the theory and application of mental hygiene would be done.

As to the program itself, it was set up after conference with representatives of the several nursing staffs. It was a triple-activity program. Primary stress was placed on individual mental health consultation with the nurses around their case material. However, emphasis was less on the solution of a family's problem than it was on developing certain skills and insights in the nurse. These consultations would last anywhere from 30 minutes to an hour and wherever possible the supervisor of nurses sat in with the consultant and the staff nurse. The second avenue of approach was by way of group case discussions in the several district offices under the leadership of the consultant. The cases were chosen by the staffs after conferring with their supervisors, and attempts were made to stimulate free discussion and new thought patterns around the nurses' relationship to a person or a family rather than to a medical entity. The third activity was clinic-centered. The consultants participated in several child health clinics, observing procedure, interviewing techniques and nurse-patient relationships. Actual nurse-patient interviews were recorded (mechanically and stenographically) and later gone over in detail in group sessions of the nurses in whose clinics the recordings were made.

The most recent period of training activity was the period of functioning of both consultants. Even though the joining of the nurse consultant in the program had been expected for some time, the distribution of responsibilities between the two workers was not a simple task. At that point, it was not clear how persons of the two different disciplines could be used together with maximum effectiveness. Consideration was given to a functional division of responsibility. However, it was finally decided to divide the areas geographically, leaving both consultants free to develop their staff programs within the areas assigned to them in relation to their

individual skills. It was hoped that the functional differences between a public health nurse consultant in mental health and a psychiatric social work consultant in mental health would evolve more clearly after some direct experience in the work. Actually, as a result of this separation of the two workers, there was some clarification in the minds of all as to the distinction between the areas of optimum functioning of the nurse and psychiatric social work consultants.

It was toward the end of the first year of the work that there became apparent a clear differentiation of amounts and types of interest taken by the different nursing groups in the continuing program. This was an important development on which further comment will be made. There was nevertheless general agreement among the nurses that the individual consultation should remain the cornerstone of the continuing training program and that each of the consultants would handle the individual interviews in the respective areas assigned to her. One new element at this phase of training was a formal educational program with the presentation by the consultants of "prepared material." The focus was on (1) the emotional factors in pregnancy and parental adjustments, and (2) normal growth and development of the infant and preschool child. This formal program of education was given more variety and substance by the showing in each of the areas of five or six mental health films.* The discussions by the nurses following these pictures and the review of the comments made in the several areas were valuable in giving the consultants insight into the way the various groups, as well as specific individuals within the groups, were developing in their acquisition of mental health understanding and skills.

Finally, the third area in which the consultants had been functioning was that of the clinics (child health, pre-natal, etc.). The nurse consultant worked in the one pre-natal clinic operated by the county health department. She attended all sessions, and held postclinic conferences with the nurses on the emotional problems presented by the patients who attended the sessions and on the emotional import of the clinic routines. A unique opportunity for further research was presented by this work in the pre-natal clinic. In the same districts where the latter clinics were held, there were

**Human Reproduction; Know Your Baby; Preface to Life; Understanding Children's Play; Children Learning by Experience;* and *Over-dependency.*

also child health clinics through which those mothers who had evidenced emotional problems before the birth of children could be followed as the children grew. Obviously, this is a long-term project and its usefulness, both as an instrument for mental health and as a mental health training device for nurses, will be clarified only in the future. A differential trend was clearly indicated as the social work consultant did not join in any clinic activities during the latter part of the program. She did, however, have a series of meetings with a group of nurses who were conducting mothers' classes to talk informally about methods of conducting these classes. The purpose of the sessions was to "think through" how the nurses could utilize the mothers' classes most effectively in helping prospective parents in their mental health adjustment.

An important area of learning, which was focused on during the later phase of training, was that of supervision. Supervision was considered with special reference to the emotional aspects of the nurse-patient and the nurse-supervisor relationships. Eight supervisors of nurses organized a workshop on problems of supervision, and the two consultants were invited to participate. The pressure of work permitted the holding of only three or four such sessions, but a very important beginning had been made by these key persons in examining their own philosophies and methods of work. In addition, the director of the county division of mental hygiene held a sequence of five two-hour meetings with the supervisors. These meetings also were on the initiative of the supervisors who requested greater clarification of the "meaning and purpose" of the Mental Health Consultant Program. It was a constructive thing that the supervisors should feel a need to keep the goals of the program in sharp focus. But what emerged that was probably more significant was the fact that—after over a year of this work—there was still great confusion in the minds of the supervisors as to what the program could or could not reasonably contribute to public health nursing. Essentially, these same confusions were present in the thinking of the staff nurses, but here they had far less practical consequence for the total teaching effort. This general lack of clarity probably had many causes, but prominent among the possibilities would be deficiencies in the teaching approach and resistances in the nurses themselves. These subjects will be considered in greater detail.

Nurses' Evaluation of the Program

As the second year of the work was coming to an end, the nurses were asked to submit anonymously their written evaluations of the Mental Health Consultant Program. To give some consistent structure to the replies, a sequence of 11 questions was given to each nurse. Seventy replies were received in a form which permitted their being tabulated. All who read the reports, however, were struck by the remarkable diversity of reactions among the nurses. The comments of several nurses working in two different offices, but with the same material and the same consultant, point this up so graphically that they will be quoted.

A nurse from one district wrote: "In evaluating the mental hygiene program of the past two years, I can sincerely say that it has been of definite value to me in my total work situation. I feel that because of this program, I am able to give better nursing service in all areas of our work. A major factor is help I have received from individual conferences with the mental health consultant upon individual situations. During the first year of this program, I probably sought help in the situations pertaining to deep and easily recognized definite problems. However, as our work advanced I found my own criteria for selection of families undergoing certain changes. In my daily work, I began including consciously mental hygiene aspects in all my patient-nurse relationships. I am slowly learning to accept my own limitations in the amount of help a nurse can give and I am making progress in gaining patience with mental hygiene in all its subtleties and in many almost intangible feelings we are called upon to work with."

In stark contrast were the comments of a nurse in a second district. She said: "At this point the staff of this district office have become, one might say, quite allergic to the Mental Hygiene Program. In fact, they are quite antagonistic to it, although they realize the great importance and the benefit to be derived from mental hygiene.

"The program in its present form is not acceptable and therefore has been rejected. However, I believe that certain changes might be made which would make the program not only more worthwhile, but would fill a decided need. We all agree that this program could be used effectively in developing and improving our own interpersonal relationships, apart from the great need presented by our patients. It would certainly be a step backward to

relinquish this program—as we have all learned that mental hygiene must have a very prominent part in all good public health nursing programs."

A summary made of the replies of the 70 nurses to certain of the key questions (Table 1) showed that 80 per cent of the nurses (52 of 65 answering) felt that the program had enabled them "to render more effective nursing service" and 85 per cent (51 of 60 answering) felt they were now better able to understand their patients' emotional reactions. There were 87 per cent (32 out of 37 answering) who indicated that they had "increased understanding of myself in relation to my work with patients." However, the wariness of the nurse where question of her own emotional involvement is concerned immediately becomes evident in the small number replying to this last question. The same is true when it is noted that 90 per cent felt that they had "better understanding of myself in relationship to my work with co-workers, supervisors, directors. . ."; but this 90 per cent was 90 per cent (29 replies) of only 32 answers received. It would seem more than likely that it was those nurses who would have answered these latter two questions in the negative who failed to give any answer at all.

Where the personal element was eliminated, the responses again rose in number. There were 88 per cent (56 out of 64 answering) who felt that the program had "been sufficiently beneficial to be continued." Of the eight negative answers to this question, five were from nurses in one district; and three of the nurses, who had reservations about continuing the program as it was, felt that it should go on in an altered form. Finally, 98 per cent (63 out of 64 answering) recommended that the position of psychiatric social work consultant, hitherto on a demonstration basis, should be made a permanent health department position. (The public health nurse consultant was already permanently on the staff.)

The nurses felt that there was a wide difference in the value of the several techniques and instruments of teaching utilized during the training period. The individual conferences with the consultant on the case material brought by the nurses were counted as most valuable. The lecture material was least effective, very little of value being retained from it. Between these two methods, in sequence, came mental hygiene movies with discussion, clinic participation by the consultants, and group discussions. It seemed quite clear that those devices which permitted the nurses to get

Table 1. Responses of 70 Nurses to Questionnaire Evaluating Results of Program

Sample questions	Total answering	Yes	No	"Yes" Percentage
Enabled to render more effective service	65	52	13	80
Better able to understand patient's emotional reactions	60	51	9	85
Increased understanding of self in relation to work with patients	37	32	5	87
Increased understanding of self in relation to work with co-workers, etc.	32	29	3	90
Program sufficiently beneficial to continue	64	56	8	88
Psychiatric social worker should be made permanent health department personnel	64	63	1	98

into "living contact" with material, identify themselves with real or imagined persons, were most effective in teaching. Role-playing was not used as a teaching instrument though Mandell[5] seemed to have excellent results with it in her work in Baltimore.

As for the changes in the program requested by the nurses, the most favored one was that there be more case presentations involving situations with emotional problems where the nurse had given service by helping people in their personal adjustments. The nurses wished the cases referred to the various mental hygiene facilities could be followed up more systematically; and, almost universally, they wanted to be closer to the mental hygiene clinics, and decried the "secrecy" and "inner sanctum" air which they felt existed in that area. There was the complaint that the personnel of other disciplines "didn't give the nurses credit for what they already knew and what they were already doing in the line of mental hygiene." A consistent reaction was that the material was "too elementary." Yet, just as frequently there was actual resentment that they had not had enough help with the "application of the material." This paradox points up the distinction universally observable in mental hygiene teaching between the student's ready ability to memorize mental hygiene rules of thumb ("too elementary") and his frustrating inability, at first at least, really to grasp and work with the emotional vitals of a situation ("But how do you apply it?"). In spite of the relatively long "basic training," many felt that "more groundwork should have been laid" and that "objectives were not clarified sufficiently for the public health nurses at the beginning."

Consultants' Evaluation of the Program

The consultants and the psychiatrist then attempted their own evaluation of the progress made by each of 108 nurses who had participated for six months or longer in the program. The ratings assigned to the nurses were the considered, but still purely subjective, opinions of the evaluators. In setting up the evaluation scheme, movement in a positive direction or "successful participation" was judged in those instances where the nurses were deemed to have gained new insights into their own and their patients' emotional processes. In almost every instance, nurses who had made progress were felt to be "emotionally involved" in the program in that they were aware of their own emotional participation (whether with positive or negative feelings) and were attempting to work through their feelings rather than to deny or repress them. Actually, an appreciable number among those who had made "progress in a positive direction" were even openly hostile toward the program as it had been organized. However, their own written evaluations confirmed the conviction that they were giving very real thought to what the project meant and how it might be revised to meet their particular needs better. (See the foregoing.) The opposite situation—where no evidences of new gains in insight were observed—was judged as movement in a negative direction, at least as far as this program was concerned.

For statistical purposes, four categories of progress were set up, two signifying movement in a positive direction, and two movement in a negative direction. Each of the 108 nurses was assigned to one of the categories. (Table 2.) In the "Plus 1" group were placed the nurses who had achieved additional insights into interpersonal relationships in general. These workers, however, had not yet been able to assimilate these insights to the point of utilizing them in their actual professional contacts. The evaluations indicated that 41 per cent of the nurses in the program (44 nurses) fell into this group. The "Plus 2" nurses had new capacity for insights and were, in addition, able to utilize such insights to the greater benefit of their patient- and staff-relationships. Workers who had made this maximum progress in their mental hygiene program numbered 14 per cent (15 nurses).

On the negative or "failure side," were considered those instances where there was no evidence of new and useful insights. The "Minus 1" group comprised the workers who showed no dis-

cernible change in understanding. These nurses were often "verbally accepting" but were emotionally noninvolved and, of course, did not utilize any new insight; 40 per cent of the participants (43 nurses) were included in this category. The "Minus 2" group was composed of nurses who, at the end of two years of training were more resistive to mental hygiene concepts than they had been at the onset. These nurses made up 5 per cent of the total group (6 nurses).

Table 2. Consultants' Evaluation of Progress of 108 Nurses

	No. nurses	Percentage of nurses
Plus 2—Additional insights with ability to utilize	15	14
Plus 1—Nurses achieving additional insight.....	44	41
Minus 1—No evidence of new and useful insights.....	43	40
Minus 2—More resistive than at onset	6	5
Totals	108	100

Although it was recognized that these evaluations of progress, as made by the mental health consultants, were completely subjective, it was nevertheless considered important to submit them to some statistical tests and study. The purpose was not to judge the validity of the ratings, but rather to discover what significant relationship might be uncovered between these ratings and other known facts or measurements regarding the same group of nurses.

The first study involved a rank order correlation between the grades given to the nurses by the mental hygiene consultants and the rank order of the nurses' adaptation statuses in their total public health nursing program. The latter evaluations were made by nursing personnel, and these ratings, too, were accepted as being subjective. The same 108 nurses were assigned by their directors and nurse supervisors to one of three general groups: (A1) new, eager, learning persons; (A2) established nurses, acclimated to their professional milieu and comfortable in their jobs; (A3) long-standing members of the nursing staffs, tending toward the static side and contented in *status quo*. The same nurses were, therefore, ranked both by consultant and by nursing personnel with respect to different criteria. The correlation which was obtained between the rankings was +.59. The correlation seemed to indicate that those nurses who were judged to show the greatest

progress in their mental health learning were the ones who were at a median level of adaptation in their nursing work—i. e., neither the newest and most eager nor the most long-standing and static. The data also indicated the possibility that there were consistent or homogeneous factors which were being used by both sets of evaluators in spite of their seemingly dissimilar criteria for judgment.

The second study was a bi-serial correlation between the number of years of public health nursing experience and the ratings given the nurses in the mental hygiene program. Here a correlation of +.62 was obtained. This correlation, like the first, is a positive one and of relatively high significance. The results indicate, generally speaking, a strong relationship between the grades obtained in the mental hygiene program and the number of years in public health nursing work. It was interesting to note that this correlation, while it holds true for the entire group, shows variations when the group is separated into three sections. If consideration is given to (1) nurses with very little experience, (2) those with the mean number of years experience, and (3) those with the greatest experience, there becomes evident a rather sharp differentiation. Those nurses who fall into the last group—those having the greatest amount of experience—show the highest correlation. There is a trend for nurses with greater experience, particularly experience exceeding the mean number of years for this group, to receive evaluations in the mental hygiene program which are lower than for the rest of the group. Actually, this is a negative trend, although the correlation is a positive one. The closer the nurse's experience lies to the mean number of years experience, and particularly if it lies within one standard deviation of the mean, the greater is the possibility of her getting the highest grades from the mental health consultants.

To examine further the relationships which were indicated by these correlative studies, tables were organized setting off the mental hygiene program ratings against the two other groups of ratings which have been described. These latter were designated as "A Ratings" and "B Ratings." The three A ratings refer to the job adaptation status of the nurses as already defined. It will be noted from Table 3 that those nurses who are classified as static (A3) accounted for 83 per cent of the "Minus 2" grades in the mental hygiene program. Those who were described as established and acclimated nurses (A2) plus those who were new and eager to

learn (A1) accounted for 100 per cent of all the "Plus 2" evaluations. Not one of the static group (A3) obtained a "Plus 2" and only 7 per cent of the static group obtained "Plus 1." This is rather significant, considering that the static group (A3) constituted 19.5 per cent of the entire nursing population. The young and eager group (A1) likewise constituted 19.5 per cent of the nursing population, yet their "Plus 1" and "Plus 2" evaluations accounted for 45 per cent of all such grades given to the total nursing population.

The B ratings refer to the number of years experience in public health nursing (Table 4). The B1 group was made up of women in the field of public health nursing from 0-2 years; B2, those from 3-5 years; B3, those from 6-10 years; and B4, those in the field 11 years and over. One observation which is evident from Table 4 is rather striking. It indicates that 100 per cent of the "Minus 2" evaluations on the marking system of the mental health consultants were obtained by those nurses having the longest years of public health nursing experience (B3 and B4). This, of course, is consistent with the correlation previously reported upon. It was also found that these same nurses with the longest experience obtained 55 per cent of the second lowest ratings, namely the "Minus 1" ratings. On the other hand, 67 per cent of the "Plus 2" ratings, which were the highest in the present system, were obtained by the nurses with the least years of public health nursing experience (B1 and B2).

The evaluation of the nurses' progress in the mental hygiene program and a consideration of their total experience in public health nursing indicate a general but sharp differentiation into two groups of nurses. The first group tends to exceed the mean for general public health nursing experience; these nurses in general did the poorest in the mental hygiene program. The second group tends to have public health nursing experience close to or slightly below the mean for the entire group; these nurses made by far the greatest strides in learning.

Discussion

Every teaching project is simultaneously a learning experience for the teachers. The work here described has extensive implications with regard to the teaching of mental hygiene; but the process of crystallizing these implications, testing them, and then re-

Distribution of Mental Hygiene Progress Evaluation for Public Health Nurses according to:

(1) Nursing Adaptation Evaluation (Table 3) and
(2) Public Health Nursing Experience (Table 4)

Table 3
N = 108

Nursing adaptation evaluations by nurse supervisors	Percentage of nursing group	Percentage of nurses for each mental hygiene evaluation			
		+2	+1	−1	−2
A1	19.5	20	25	16	0
A2	61.0	80	68	51	17
A3	19.5	0	7	33	83

Definition: A1—"New, eager, learning persons";
A2—"Established nurses, acclimated to their professional milieu and comfortable in their jobs";
A3—"Long-standing members of the nursing staffs; tending toward the static side and contented in *status quo.*"

Table 4
N = 108

Public health nursing experience	Percentage of nursing group	Percentage of nurses for each mental hygiene evaluation			
		+2	+1	−1	−2
B1 (0-2 years)	22.0	33.5	30.0	14.0	0.0
B2 (3-5 years)	29.0	33.5	30.0	31.0	0.0
B3 (6-10 years)	17.0	20.0	11.0	16.0	50.0
B4 (11 years and over)	32.0	13.0	29.0	39.0	50.0

crystallizing them is essentially a long one. In this group-teaching experience the seemingly simple goal was to give to the nurses a basic and utilizable knowledge of the principles of mental hygiene. However, the learning process observed here was not the learning process which is usually evident when a given body of "basic" material is assimilated. The process was, in fact, so exaggeratedly slow and tortuous that attention might well be directed toward finding the causes which determine the slow rate of learning—i. e., real learning which predicates the ability to utilize the material learned. Is there something unique about the subject matter of mental hygiene, or was there something in the way in which it was taught in this particular project which explains the retarded learning tempo noted?

For purposes of this study, the public health nurses form a fairly homogeneous student-group.* They are persons of approximately similar general capacities and professional backgrounds. The nurses' conscious readiness to learn can, with some few exceptions, be assumed, since the program had been carefully planned and took its origin from their own expressed needs. True, other factors than these obviously influence the learning tempo in such a project. Among these would be the teaching devices utilized and the personalities of the teachers. However, it could not be determined that either of these elements played a major role in bringing about the slow learning rate.

The most striking and consistent observation to come out of this project has been the tremendous strength of the resistances blocking the effective understanding and assimilation by many nurses of certain basic concepts of interpersonal relations in mental health work. It is suggested, therefore, that the fundamental difficulty here lay in large part in the nature of the subject matter of mental hygiene. In almost every instance, the public health nurse tries with honesty and sincerity to grasp these basic concepts. However, after a time, there are clearly discernible in all the nurses certain deep-seated emotional reactions of conscious or unconscious fears which prevent a nurse from making this knowledge "her own" to the extent that she would like and that would provide maximum benefit for her work with patients. This blocking is the more difficult to handle, since the learner's own unconscious fears of self-knowledge or self-revelation—inevitable accompaniments of this type of work—give rise to "blind spots" which, on the one hand, prevent her from even noticing certain pathologies of interpersonal relationships in others, and on the other hand make it impossible for her to become aware of her own defensive "blindness." The blockings often persist, even after concerted efforts have been made to interpret the origins of her resistances to her.

It should be pointed out that the nurses are no different in respect to this "blindness" from any other professional group, nor, for that matter, are they different from any other human individuals. For instance, Greenhill and Kilgore[6] summarize their work

*In the light of continuing studies in this project, this statement has seemed to be unfounded—at least as far as the authors' group of nurses is concerned. Work to be published later by two of the authors (Kline and Cumings) has highlighted considerable lack of homogeneity in such vital areas as general intelligence, personal attitudes, etc.

in attempting to teach mental hygiene to medical residents in the following terms: "The resistance of the trainees to the approach was the major factor to consider. . . . That this resistance is an important factor is known to everyone; but its persistance, the forms in which it operates, the way in which it shifts as instruction proceeds, and the fact that with intensive teaching over two years' time it still remains as a potent force is perhaps not fully appreciated. . . . The job of training medical personnel in the psychiatric approach cannot be taken lightly and with too much optimism. It is possible only with great expenditure of effort and time, with results not proportional to the effort. Our data showed that even with intensive instruction only approximately one-third of trainees satisfactorily learn to utilize the approach. Forty per cent learn nothing. What the remainder learn is slight."

The evidence also seems to indicate that though all professionals bring to this kind of work the same resistances, fears, and blind spots, certain professionals—those at a higher level of knowledge and training—paradoxically seem even more fixed in their attitudes and preconceptions than those relatively new in the profession. Greenhill's experiences in this connection too have been identical. In a later paper[7] he reports that the further along the physician is in his professional development, the more difficult it is to teach him the practice of "comprehensive medicine" (defined as "recognizing, evaluating and treating all of the physical, social and emotional variables which are an integral part of the disease process"). Second-year medical students learn the approach with greater facility than do fourth-year medical students; fourth-year students acquire this knowledge and technique in higher percentages than do house officers; house officers assimilate decidedly more than do men already in the medical field. It was the present writers' observation that, in general, public health nurses recently graduated seemed to show more readiness to accept and integrate the new concepts into their relationships with patients than did nurses many years in practice. Of course, this may in part be due to the fact that in recent years schools of nursing have been giving a more effective training in mental hygiene. This is at best only part of the answer, however.

In spite of the fact that those who planned this demonstration project were aware of the difficulties that might be met, they were not prepared for the pervasiveness and intensity of the resistances

that actually cropped up. It has been known, for example, that in several previous projects in which social workers and public health nurses had been used conjointly as consultants in service and training, severe rivalries had arisen. These had gone on into frank hostility between the two disciplines which had, in several instances, ended up with the projects being abandoned—or, at least, the workers of the two disciplines were separated and used independently. Still, even with all the personnel participating in this present project keenly alerted to the various dangers, the "rough spots" developed with a fine inevitability. Conflicts soon appeared between nursing personnel and consultants, between social worker and nurse consultant, and finally between nursing personnel, consultants and psychiatrist. The history of the program to date has been one of continuous striving to recognize, at the earliest possible level, conflicts and resistances in all persons involved and to handle them actively and overtly in group and individual conferences.

The resistances were couched characteristically in plausible and rational terms; but their true nature seemed, nevertheless, evident. Those groups whose resistances were high now asked to be involved "less intensively" in the work. Time for consultation and group meetings was cut from two days to one day a month in these areas. Some nurses who expressed disappointment in what they had gained from the program felt that they would like to change consultants, from the social worker to the public health nurse. It appeared to them that it was the difference between their own background and philosophy and that of the social work consultant that made the learning process so slow for them. Later there was consistent failure on the part of the nurses to come to individual conferences with summaries of case material prepared. Tardiness at meetings, non-participation in discussion groups, failure to utilize hours available for conference: These and many other shapes and forms of resistance were noted.

Now, since resistance is a process generally outside the person's awareness, it is up to the teachers in this kind of project to be constantly alert to its recognition as it arises. By definition, resistances are universal in all people; they are just as prevalent in the supervisors, directors, consultants and psychiatrists as they are in the staff nurses. However, these resistances in personnel at the administrative and supervisory level obviously present a special problem. Those supervisors whose unconscious resistances

are particularly powerful will determine or foster the resistive elements in their particular staff nurses. Such was certainly the experience in this project.

After the project had been under way about a year, the supervisors themselves, as it turned out, became increasingly aware of their need for special work in the area of mental hygiene. They worked out the series of seminars on "interpersonal relationships in supervision." However, neither this device nor others attempted were particularly successful in advancing the emotional insights of the supervisory group beyond those of the staff nurses to the same extent that their general nursing knowledge exceeded that of their staffs. This was important, since, by and large, this state of affairs posed a threat to the supervisors, who felt that they "should know more about mental hygiene" than their staff nurses. Yet in their further distance from their basic training, in their more definitive character formations, and in their lesser opportunities to carry cases and become involved personally in conferences with consultants, just the opposite was more likely to be true. The supervisors as a group were observed to be more "service-centered," less "relationship-centered." It seemed to be true that the progress of several of the area staffs in the mental health learning process bore some positive correlation to the reactions of the supervisors of these areas. This would be expected, since the general type of nurse and philosophy of nursing in each area is to a considerable extent determined by the personality of the supervisors and the director of nursing. This fact was also important, because the resistive supervisor consciously or unconsciously blocks efforts to come to grips with the resistances of her staff.

One other clarification needs to be attempted: a differentiation of the specialized functions of the nurse and psychiatric social work mental health consultants. Since the average nursing agency would not have the opportunity to obtain the services of two consultants of different disciplines, public health nursing in general would profit by any light thrown on the question of the different areas of maximum effectiveness of the two consultants. Such a definition would make it possible, for example, for nursing personnel to choose a consultant with background and training appropriate to their own particular needs and to the expectations of their program.

To begin with, either consultant is equipped to help plan for the integration of mental hygiene principles into public health nursing instruction. Either can actively assist in staff education programs directed ultimately toward the prevention of behavior or emotional disorders, and they can confer with nursing personnel on methods of recognizing and handling situations where help is indicated. But beyond, and even within, these areas of common competence have emerged areas of particular competence for each consultant. The very fact that there is no great clarity about these areas at this time betokens the immaturity of the work in this field and probably also the presence of strong emotional factors operating to cloud the perceptions of all personnel involved. The loyalties of nurses, psychiatric social workers and physicians to the traditional operating patterns of their own disciplines are very strong and may be one of the causes of this clouding. Experience has abundantly proved that interdisciplinary rivalries are powerful and sometimes destructive influences in such projects as this one.

In considering the qualifications for a mental health consultant to public health nurses, many factors must be kept in mind, yet one would seem paramount. The primary stock-in-trade of the mental health consultant is not a knowledge of public health, nursing, medicine, or social work. It is a comprehensive knowledge of the dynamics of human behavior and a knowledge of what goes into healthy emotional living. It is certainly true that the two types of consultants functioning in this project are not identically equipped with this knowledge. The average psychiatric social work consultant today has had far more formal training in, and actual experience with, the dynamics of human behavior than the nurse consultant. But here a paradox has become evident; for at the present point in the mental hygiene education of public health nurses, the nurse consultant with brief, intensive training in mental hygiene is generally more acceptable to the learners themselves. Indeed, it has proved to be very difficult for most nurses to identify with a consultant from a different discipline. This difficulty then would seem to neutralize or even outweigh the theoretical value of the social worker's greater knowledge of human emotional processes. The nurse has the added advantage of a more intimate knowledge of the field into which the mental hygiene concepts are being translated.

The impression emerges that with their very divergent backgrounds and the different attitudes they engender, the two consultants cannot perform identical roles. In this program, over the past year, certain convictions have evolved concerning the special areas of effectiveness of the two workers. These are offered tentatively and subject to confirmation through continuing experience. The public health nurse has shown herself to be generally the better equipped person to handle the consultative duties revolving around the nurse's work in the pre-natal, child health, and other clinics. She has been able to involve herself in these clinics with a sharp discernment for the points at which changes that would be constructive from the emotional viewpoint could be made. This has included suggestions with regard to clinic procedure, the nurses' interviews with the clinic patients, and brief group and individual conferences with the nurses around the clinic cases at the close of the day.

The psychiatric social worker has proved herself particularly valuable through her use of the individual conferences as a means of helping the nurse to develop new skill in utilizing the nurse-patient relationship. This new skill consists for the most part of a conscious use by the nurse of her own attitudes and feelings in her contacts with families. She has also helped through giving consultation and guidance to the nurse in her work with patients having more complex emotional or social problems.

Through the use of the two consultants "indiscriminately" in this program for a period of nine months, their complementary relationship, as just described, soon became evident. The "indiscriminate" use emerged as rather unrealistic. The psychiatric social worker without special nursing training cannot function as comfortably and effectively in the fundamentally medical setting of the clinic as can the nurse consultant. The details of nursing and medical procedures are not intimately known to her—nor, correspondingly, are the emotional significances of the special pathologies of child-bearing, tuberculosis, venereal disease, orthopedic disabilities, etc. On the other hand, many nurse mental health consultants, as graduated today, come to their jobs from two-year training courses in mental hygiene. Generally, they have had only brief mental health field work placements, and little personal experience in the specific handling of the emotional disorders of people. Yet the nurse consultants—with minimum training in mental

health—are viewed inevitably by the nurses as consultants, not only in the area of emotional health, but also in the area of emotional illness. This is a rather untenable position for these workers to be in.

Two consultants, each specializing in one particular area but with competence in the second area, are most effectively utilized conjointly. Only in this pattern can optimum consultation coverage be attained.

Dr. Kent Zimmerman[8] has tied in the foregoing problems with one final consideration. "The right to teach human relations lies not only with those who are conversant with this subject, but also with those who have the ability to teach it from the personality standpoint. It is my feeling, therefore, that any person who has this ability should be used providing his training has given him the sense of his limitations as well as the potential of learning on the job."

Summary

1. A two-year in-service Mental Hygiene Training Program involving more than 160 public health nurses is described in detail. Two mental health consultants (a nurse and a psychiatric social worker) were the primary instruments of teaching.

2. The nurses' evaluation of the effectiveness of the program is given. The consultants attempted an evaluation of the progress made by the nurses.

3. The rate of learning mental hygiene is recognized to be slow: This experience emphasizes that fact. Of the participating nurses 41 per cent were considered to have achieved some new insights into human relations. An additional 14 per cent were judged both to have achieved and to have begun to utilize new mental hygiene knowledge in their work as a result of the training described here. The nurses who made the greatest progress were those who had attained a certain state of adaptation to their public health functioning and were in point of experience closest to, or slightly below, the mean for the entire group.

4. Possible explanations for the slow rate of learning are considered, main emphasis being placed on the phenomenon of resistance. This appeared to be the most important single block to learning.

5. An attempt is made to differentiate the areas of maximum effectiveness of functioning of the consultants from the two disciplines. The conclusion is expressed that their roles, at the present level of development of such mental hygiene training programs, are complementary. They should not be utilized indiscriminately, but only with a specific awareness of their respective areas of optimum functioning.

6. The present study is preliminary and general. It is evident that carefully planned and controlled experiments should continue from this point. Techniques are needed for discerning and resolving resistances met within a group setting. Such research must of necessity be expensive in time, money, and energy; but it is indicated in view of the tremendous problem presented by emotional disorders and the demonstrated difficulties of training personnel to recognize and cope with these disorders.

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THE VALUE OF THE THEMATIC APPERCEPTION TEST IN MENTAL DEFICIENCY

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The Thematic Apperception Test is a projective instrument consisting of a set of 19 picture cards and one blank card, arranged in a definite order designed to stimulate responses of strategic value in the exploration of concealed mental processes. The present study is concerned with the results of this test, administered to 50 institutionalized mental defectives.

The validity of the TAT, like that of most projective tests, depends on the degree to which the subject projects by the process of identification, elements conscious or unconscious, of his own past or present personality and of other figures, such as parents, siblings and loved objects, and on the degree to which he utilizes conscious or repressed components, apperceived or fantasied, in his characterizations of the heroes and other major figures of his stories and in his portrayal of their actions or reactions.

As a rule a small fraction of the variable material which makes up a set of stories contains important constituents which can be used to construct the personality. Much of the protocol is waste material. One must sift out the essential particles disguised in the TAT protocols of patients by closely studying and observing their reactions and behavior in life situations.

The administration of this test is simple. The only instructions necessary are to inform the subject that he is to tell a story about each card as it is presented to him, a story in which he is to be sure to include a plot and a definite ending. Repeated guidance, inquiry, and words of praise are necessary. With mentally deficient subjects, the present writers do not adhere strictly to time limits. Also, whereas with subjects of normal intelligence, stories of less than 200 words indicate defective rapport; in all of the present writers' group of 50 mentally defective cases, they averaged 120 to 150 words under optimum conditions with good rapport. The writers usually present no fewer than 10 and no more than 16 cards, eliminating those which stimulate similar themes.

The TAT is used in mental illness more often than in mental deficiency because of the assumption that the mental defective is incapable of producing lengthy, vivid, dramatic and provocative narratives. According to Masserman and Balken,[1] fantasies of

mentally deficient patients show a characteristic "naivete of material and dearth of imagery." One of the aims of the present communication is to dispel this supposition and thus establish the value of the TAT in the field of mental deficiency. Furthermore, in the writers' application of this device in the examination of institutionalized mental defectives at Newark (N. Y.) State School, they note that in many cases this technique is the only method of obtaining plausible productions from these patients. In some cases, the material obtained, when analyzed, has been of great psychiatric value in developing the diagnoses, dynamics and treatment of these cases. The other projective techniques have not been so fruitful. Of broader significance is the heartening contribution that the TAT has made to the field of mental deficiency, in awakening people to the fact that the defective individual is not simply an intelligence rating, but is a personality who has fears, anxieties, wishes and needs which affect his intelligence in varying degrees and courses.

The concept of mental deficiency is emerging from a morass of homogeneity. This is a happy development; but, unfortunately, this section of psychiatry seems to be only entering a stage similar to that which existed with regard to mental illness about three-quarters of a century ago, when psychiatrists were finally liberated from the idea that the mentally ill formed a rigid, undifferentiated, homogeneous and indistinctive heap of humanity to be removed from society, isolated and imprisoned. The great classifiers destroyed this medieval notion of uniformity and established the heterogeneity of the various forms of mental illness. Intensive inquiry into the origin, sources and fundamental nature of these clinical entities led to subsequent explorations for genetic and dynamic evaluations, even within the frameworks of single clinical entities.

An analogous situation to that formerly existing in the field of mental illness now exists in the field of mental deficiency. Clinical categories of mental deficiency are now being lifted out of a previously existing amorphous bulk of mental defectives. Clear classifications and definitions of a large variety of conditions of different structure and origin which comprise the heading of mental deficiency is unfolding. Of greater significance, is the increasing interest of psychiatrists in mental defect and the acceptance of the attitude fostered by dynamic psychiatry of the integration

of the total personality with phylogenetic, ontogenetic, and environmental determinants.

Guided by this principle, the writers have not merely lumped together in the generic sense all the mental defectives in this study and disregarded variables, as is still being done in the studies of heredity, EEG, behavior and delinquent tendencies, scholastic and community adjustment of mental defectives, etc. The writers have chosen and evaluated their material in relation to genetic, cultural, physical, emotional and other determinants. The TAT has been a valuable aid in these evaluations and correlations.

In this study, the writers have avoided using cases which Kanner[2] groups under the heading of "absolute feeblemindedness." He includes in this category individuals who are so markedly deficient in their potentialities that they would stand out as mental defectives in any existing civilization. They are those who can be designated irreversible idiots and imbeciles.

The investigations are confined here to his two other groups of mental defectives, which he classifies as relative feeblemindedness and pseudo-feeblemindedness. The former is comprised of individuals whose limitations are definitely related to the standards of the particular culture in which they exist. Their principal difficulty is a greater or lesser degree of inability to cope with the intellectual requirements of their society. The latter group includes individuals who are "apparently" defective.

The problem of diagnosis and treatment in many cases of mental deficiency, particularly in the relative and apparent mentally defective varieties, is not an easy one; although, in most cases of retarded development, the pattern is reflected in all areas of functioning in a clear and consistent manner, thereby posing no diagnostic difficulties except as to etiology. There are cases of psychiatric significance in which the intellectual retardation is apparent, and in which there is scattering and inconsistency in the functional levels in other areas, as well as in the intellectual sphere. There seems to be another disorder than retarded development in operation in these cases, a disorder which, upon close investigation, may prove to be the primary and more important condition. Unfortunately, these cases are relegated rather hurriedly to the category of mental deficiency and are disposed of accordingly.

There is need in the field of child psychiatry for improvement in the evaluation, systematization and diagnosis of abnormal be-

havior. This field is an untapped reservoir of scientific concentration which cannot be surveyed simply in the pattern of adult psychiatry.

In the interests of improved diagnosis of childhood disorders, especially in the evaluation of intellectual retardation in relation to the total personality, the writers have undertaken the present endeavor in the hope that the TAT will be a more successful adjuvant than the many other tests available at the present time.

In classifying the material, the writers have not only followed the broad groupings mentioned, but have also utilized the present classification of behavior disorders in children in the breakdown, in order to ascertain the specific factors and themes underlying the various types of disorders found in the mental defectives, so as to compare the mechanisms with the dynamics of similar disorders in nondefective children. In this manner, one can establish a long-disregarded principle—that the mental defective has a personality just like any other individual.

In the interests of brevity, the writers will not outline the various conditions in which retardation may be present as a secondary manifestation, or may be of the lesser importance even if co-existing with another condition. In fact, if one wishes to be compendious, one can succinctly state that all childhood disorders present the problem of mental deficiency.

Of the problems and disorders presented by children, the primary behavior disorders are most frequently associated with, or mistaken for, mental deficiency. To be sure, our mental defectives, especially the higher grade types, are prone to behavior anomalies. Nevertheless there are many cases of borderline intelligence where the personality disorder is the prime condition, and the emphasis on poor judgment associated with the slight mental retardation is unwarranted. Furthermore, as frequently happens in some of these cases, the measurable retardation—particularly the educational disabilities which exist in conjunction with the behavior problem—is reversible and, therefore, should not be simply connected with borderline or dull normal intelligence and left untreated.

The notation "primary" is used in these disorders to denote that they are not secondary to another pathological condition. They develop in reaction to environmental influences, are in the form of

persisting behavior patterns, and, as such, can be considered reactive disorders.

Conduct disturbances, along with habit disturbances and neurotic traits, form the bulk of the primary behavior disorders. A few of the types of recurrent problems encountered under the heading of primary conduct disturbances are: chronic, aggressive reactions; cruelty and destructiveness; and delinquencies. As a general rule, it is customary to speak of a conduct disorder whenever there is a deviation from the accepted code of morals, and, as such, it is often referred to as a character disorder.

Habit disturbances such as thumbsucking, nail-biting, enuresis, masturbation; and less frequently, neurotic traits such as tics and spasms, nightmares, sleepwalking, fears, and overactivity, are often present in combination with the foregoing symptoms in this type of problem. Ill-defined and undiagnosed personality disorders, involving seclusive states, suicidal trends, excessive introspection, etc., are also included in the broad area of primary behavior disorders.

In view of the protean nature of this category and the fact that the patterns of behavior—together with the early onset, the type of personality, and the disturbed early environment are factors present also found in mental deficiency—it often becomes necessary to rule out mental deficiency in these cases. For the same reason, the question of primary behavior disorders must be carefully considered in some of the cases of mental deficiency, where a pseudo-mental defective may exist.

Primary Behavior Disorder Patterns

Sixteen cases of the 50 (27 males and 23 females), studied in this paper presented problems clinically which would place them in the broad classification of primary behavior disorders were it not for their subnormal IQ scores. The following two are cited as examples of this group:

Case 1

L. M. is a 14-year-old, attractive, white youth who was admitted to Newark State School on February 15, 1949. He was classified as a borderline mental defective with an IQ of 78. He had been raised in a home environment where he had received inadequate supervision and had been subject to unwholesome influences.

He had done poorly in school because of a lack of interest in academic studies. His favorite subject had been shopwork, and—apparently—when he had concentrated on a subject, he had succeeded in earning passing marks. However, he had been more of a social than a school problem because of his repeated quarrelling with the other boys. Finally after a repetition of acts of sexual misconduct, he was certified to Newark State School.

It was apparent from a study of his home environment that neither parent showed much interest in this patient, so that he lacked affection and attention. Family indoctrination and supervision of the boy were very inadequate.

L. M. appears to be a friendly, though rebellious and resistive individual. When questioned about past difficulties, especially in regard to his family, he gives vague responses which on the surface appear superficial and stereotyped. He expresses much hostility in regard to the institution and feels that he is constantly being "picked on." His statements create a picture of continual conflict with his environment, to which he responds in terms of negativistic, resistive behavior. He gives a long history of having had difficulty with authoritarian figures and expresses a strong preference for his mother as opposed to his father, who appears to have been a strong authoritative figure. He is subject to transitory episodes of acute anxiety, with syncope, perplexity and confusion. He also has moods of depression. These attacks usually follow his bursts of aggressive rebellion. At times they are associated with sexual panic.

The TAT helped to confirm, develop and elaborate the clinical picture and analysis which follows:

"This boy is in continual conflict with his environment. Confused identifications play an important role in this case. He has strong feelings of rejection and abandonment in regard to both parents with accompanying feelings of repressed hostility toward them. In conscious life, he attempts to cope with these feelings by means of reaction formation and displacement. However, he is unable to escape the consequences of these conflictive forces, for there is a strong element of guilt present, arising from the tension produced by an early formed, rigid, moralistic concept. His concept of the father is a moralistic, authoritarian figure in regard to whom he is forced toward a submissive role. Here he is faced with an ambivalence of being submissive to authority and of striking

out against it. He thus presents a rigid front to reality situations —behind which strong, primitive, aggressive forces are kept in a state of repression.

"A stronger identification exists with the mother figure to whom he relates more easily. Here, also, feelings of rejection and hostility are strong with fantasied ideas of one day being loved by her again. Because of this relatively strong, rigid superego, he is forced to repress his strong, antisocial feelings and instinctive demands, responding by either negativistic resistance or by passive resistance in the shape of lack of interest and inertia. At times he flees from social situations into acute catatonic reactions of syncope, perplexity and confusion. He is thereby overcome with a strong sense of inadequacy, failure and frustration, which accounts for shifting moods in which depression is common. These feelings of frustration motivate much of his conduct for he is ineffectual in dealing with these frustrations, resorting here also to resistance, rebellion, inertia, and paranoid explanations.

"He has difficulty establishing close emotional relationships with people and looks upon them with ambivalence. He is suspicious of those who show him affection and friendship, fearing injury and betrayal from them. His feelings of deprivation and persecution are omnipresent and ubiquitous. In this sense also he displaces his own feelings of guilt and inadequacy onto others.

"In the sexual sphere, anxiety mounting to panic proportions at times exists. In this area, homosexuality and masturbation operate. Here we also note the quality of sadism and masochistic punishment indicating the internalization of aggression onto the self."

Case 2

R. P. is a 12-year-old attractive youth who was admitted to Newark State School on December 29, 1949 with an IQ of 78. He had been a behavior problem most of his life, chiefly because of a conduct disorder highlighted by cruelty, violent aggression, petty thievery and sexual misconduct.

The family background was of interest. The father was described as an unstable, inconsistent, strict disciplinarian. The mother was said to be inadequate. Of the nine siblings, an older brother was alleged to have been active sexually with the patient, and a younger sister was the object of unusual sexual interest on the part of the patient and his brother.

This boy is rigid, indifferent, and free of guilt on the surface. Nevertheless, he is emotionally disturbed inwardly. He has strong sadistic tendencies. He cannot establish or maintain satisfactory personal relationships. There is absence of affect in his relationships to people. He tries to control his aggression by flight from social situations. He constantly wants to flee to the woods. He also has episodes of confusion and mutism. He projects his own impulses to hurt children, particularly sibling figures.

This boy's TAT protocol expresses vividly his conflict with his environment, which he externalizes in aggressive, antisocial acts. The basis of the conflict appears to be his rejection of authoritative figures who, he feels, oppress and rob him of pleasures to which he is entitled. There are indications of an Oedipal conflict underlying these factors. In many of his stories he, the hero, attempts to prove himself as capable as the older male figure. He can move in and assume the care of the mother and of himself without the father's intervention. Having been rejected by the mother, for whom he feels a strong attachment, and also by the father, with whom he is in conflict as a rival, he finds it difficult to relate to all parent figures, and he is unable to solve the Oedipal conflict successfully.

His desire to overcome the father seems to create a situation where he feels he must show his strength in every relationship with older males. This also applies to siblings who, he feels, have usurped the maternal affection due him. His desire for maternal love is expressed in fantasy form. Accompanying these desires are typical guilt feelings and fear of punishment in the form of castration phobias. Because of these strong, instinctive forces, he withdraws from all normal sex situations. Being weighted down by his aggressive impulses toward his environment and the demands of his environment to control such impulses, he withdraws to earlier levels where less will be expected of him. He wishes to attain control of his inner compulsions and longs for a strong ego ideal to overcome them, but the conflicts deprive him of the strength to attain these optimistic goals.

The two cases just presented are illustrative of the tendency to consider problems involving conduct and other disturbances only in the light of an existing oligophrenic process—which may or may not be verifiable—and to ignore the more important factors and mechanisms, usually stemming from environmental chaos. The

TAT protocols of this "primary behavior disorder" group of cases presented the following significant themes:

1. Hostility to authority figures (88 per cent).
2. Desire for acceptance and affection (75 per cent).
3. Ambivalence to authority figures (69 per cent).
4. Feelings of depression (69 per cent).
5. Desire for protection and security (63 per cent).
6. Aggression (63 per cent). The aggression was directed against the identification figures as well as initiated by them against others.
7. Particularly good stories on the blank card (16); often the longest stories of the protocol and those told with the greatest display of affect. The free imagination of the subjects in this group seemed stimulated, and stories mainly of the wish-fulfillment variety were produced.

In studying the history, clinical reactions and TAT protocols of the cases in this group, one invariably finds a great amount of disharmony in the patient's family background or an exceedingly wretched family environment, or no set family background.

We are all aware of the importance of parental attitudes toward the child. In these cases, the parental attitudes or the attitudes of the foster parents (who may change many times) engender feelings of depression, rejection, hostility, aloneness, insecurity, anxiety and abnormal aggression against environment, with or without guilt. There is no developing super-ego, which emerges when the aggressiveness released by infantile impulses and frustration is internalized, and the impulses are sacrificed for the compensation of parental affection. The child turns much of his aggressiveness against his environment and little of it inward toward the development of a super-ego for use against the ego, so that he usually appears free of remorse, self-criticism and reproach. As a consequence, object relationships are disturbed.

What usually develops is a rigid, moralistic concept unmodified by intelligence, good lasting identifications, and social influences. The rigid, immature super-ego is a severe, authoritarian figure. The conception of right and wrong is entirely related to the punishment concept. In this connection, although such children outwardly seem unconcerned and without remorse in regard to their

actions, inwardly they are concerned with the conflict between good and bad; so that as in the primary behavior disorders without any question of mental retardation, they appear to be relatively free of conscious guilt, expressing no remorse or guilt. Subconsciously however, they give evidence of the activity of the infantile super-ego as represented by feelings of inferiority and depression and a tendency toward self-punishment. Where neurotic traits and bad habits do occur, these are defense manifestations and acts which stubbornly persist from unconscious conflict at earlier stages of development. In conduct disturbances, the aggression is utilized as an offensive rebellion.

Psychopathic Patterns

There were 12 cases in this series whose clinical patterns could be categorized under the heading of psychopathic personality, were it not for their mental defects.

The designation of psychopathic personality is as undesirable as the term primary behavior disorders. Actually the two conditions are very much alike except for the tenuous distinction as to etiology, which implies (in historic derivation of the nomenclature and for other reasons) a constitutional factor, and which limits the term, psychopathic personality, to those cases who have an "inherent" inability to develop normal super-egos. They manifest the same amoral and asocial trends as persons with primary behavior disorders, but these "psychopathic" trends are basically prenatal in etiology and only partly reactive to environmental influences. Since psychopaths are strongly inclined "constitutionally" toward patterns of social disorganization, they are vulnerable to unwholesome environmental influences very early in life.

There is a close proximity of the behavior problems of the mental defective to those of the psychopathic personality, because of the former's unregulated emotional system which causes him to react inadequately to situations, because of the supremacy of his primitive drives, and, finally, because of his inability to profit from experience. In many cases, particularly in the higher grades of mental deficiency, both factors are operative.

Case 3

G. K. is an 18-year-old white adolescent who was completely neglected as a child and raised in a deplorable home environment. He was a lifelong social problem because of his destructiveness

and vagabondish tendencies. He ran about aimlessly, was difficult to manage wherever he happened to be. He had no fear of discipline. Because of his psychopathic personality and an IQ of 52, he was excluded from school and committed to Newark State School, where for years he had been a behavior problem.

This boy's IQ of 52 is probably not an accurate indicator of his inherent intelligence. He is alert, obtrusive and possessed of cunning and an uncanny ability at executing conspiracies and concocting contrivances for accomplishing his revengeful, antisocial schemes. It is as though, in carrying out his aggressive strikes against society, he obtains a great deal of ego-satisfaction at outsmarting and outmaneuvering others. Between plots and episodes of larceny, violence and destructiveness, he presents a façade of amiability and gentleness, and he stands out as an excellent worker.

Because of his strong tendency toward untruthfulness, the TAT was a more effective instrument of contact with this patient than the usual interviews. In the test setting, he discusses his problems and past difficulties and manufactures his themes with little concern. He seems to feel that he has been the victim of circumstances, that he has had little responsibility for his difficulties and little control over his destiny. For example, a typical expression of his bland detachment is his statement after telling a story of death, "They feel sorry, but they'll get over it. We all have to some day." He seems to take great pride in physical strength, of which he feels he has an abundance; and, in the content of most stories, those persons possessing strength and daring are the heroes. Nearly all of the themes have to do with violence and antisocial acts, some of which are caused by the hero, others directed against the hero. All these activities are projected with impersonal fatalism, and no particular hostility is expressed as the cause of his extensive imagery of destruction.

The protocols of the individuals who presented the constitutional psychopathic pattern clinically varied somewhat. The following is a compilation of the themes revealed in their TAT records:

1. Hostility to authority (parental figures) resulting in an inability to relate to such figures (75 per cent).
2. A feeling of aloneness and isolation stemming from actual rejection by parents and inability to form close relationships (67 per cent).

3. The presence of violent aggression directed against others and occasionally internalized (50 per cent))
4. A tendency to idealize the identification figure in an effort to compensate for the frustration experienced in reality.
5. An attitude of fatalism and defeatism arising out of confusion, indecision, failure to set up an ego ideal and general dissatisfaction with life.
6. There is no definite pattern relating to guilt feelings, although guilt feelings are experienced in 42 per cent of the cases and feelings of depression in 50 per cent.

It is noteworthy that in these cases of both psychopathic personality and primary behavior disorders, the narcissistic self-evaluation that is said to be characteristic of these two conditions was conspicuously absent. The writers have already pointed out that there is a defective development of guilt feelings, and, even though the individuals with these conditions may superficially appear unconcerned, guilt feelings may exist inwardly. The most consistent finding in the writers' cases was that of abnormal aggression toward the environment, which occurred in 63 per cent of the primary behavior group and in 50 per cent of the psychopathic group. It is, therefore, to be concluded that the triad of (1) abnormal aggression toward the environment, (2) absence of guilt feelings, (3) narcissistic self-evaluation, which is usually associated with primary behavior disorders and psychopathy, is not a distinctive pattern of our cases of institutional mental defectives with similar behavior patterns.

Schizophrenic Patterns

A substantial number of cases admitted demonstrate schizophrenic reactions. This subject was covered extensively in a previous communication by Bergman et al.[3] Ten patients in the present study were classified in this group.

Schizophrenic reactions in children are not infrequently mistaken for mental deficiency. The IQ alone is not sufficient to establish a diagnosis of a mental defect. There are many similarities between the schizophrenic child and the mentally deficient child, in problems involving motility, perception, thought, language, affect and social behavior.

Mental deficiency is often used as a diagnosis of social inadaptability. Since social incapacity is characteristic of schizophrenics, individuals with this type of problem are often considered mental defectives when they regress or fail to progress, so that their reactions are on a level with dull normal or borderline, or even lower, types of socially maladjusted mental defectives.

Case 4

D. B. is an eight-year-old, white boy with an IQ of 87, who, despite his IQ, manifests marked immaturity in all areas of development. He presents an infantile speech defect and demonstrates emotional peculiarities and ambiguities, odd mannerisms and marked blocking in his verbal responses.

The outstanding recurrent trend throughout his entire TAT protocol is that of flight. He either is running away or he has already withdrawn. With little display of affect, identifications appear to be easily made with killers and others who "were bad"—projections of his primitive impulses. One reference of this sort was directed against his mother. However, there seems to be a basic underlying element of guilt, in that he feels he has undesirable qualities that must be destroyed. An Oedipal conflict appears to be generating guilt with suicidal references.

D. B.'s inner turmoil is depicted in the form of storms and strong upheavals of various types. These situations, plus fantasies of inferiority and inadequacy relating to his failure to assume the role of the potent father figure, precede the escape or the eventual overpowering of the hero. He then withdraws from all conflicts with inner forces and reality into compensatory fantasies in which he pictures himself as the ideal character, the virile, accomplished father figure. The content of his stories is morbid and bizarre with death a predominant motif.

The following patterns were prominent in the protocols of this group of 10 schizophrenic pattern cases:

1. Withdrawal from reality situations and inner struggles (100 per cent).
2. Guilt feelings in association with primitive drives (100 per cent).
3. Role of dependency and submissiveness (100 per cent).

4. Projected anxiety and negativism with no affect in relating the stories (70 per cent).
5. Feelings of inferiority and rejection (70 per cent).
6. Bizarre and morbid content of stories (60 per cent).
7. Sexual and ideational confusion. Unlike the pure mental defective, who is able to create simple, coherent sequences and to identify himself with his own sex, this type of patient is unable to construct coherent stories and is confused in regard to his sexual role.
8. The presence of strong moralistic qualities suggesting a more highly developed super-ego than in the other conditions.

Psychoneurotic Patterns

The view often expressed that the mental defective is not capable of psychoneurotic elaborations is not tenable. It cannot be stressed enough that the mental defective could and would find his place in society were it not for the very environmental and social factors and circumstances which lead to anxiety even in normal individuals. In many instances, the mental defective is crippled by a harsh reality. This is proved by the successful adjustment of many other mental defectives with similar and even more advanced intellectual defects.

The mental defective's resemblances to the psychoneurotic arise out of his susceptibility to anxiety because of his basic inferiority and because of the fact that once a symptom is created, it is more difficult to remove.

In this type of problem, the neurotic pattern evoked is usually an outgrowth of failure, because of basic inferiority, to adjust adequately to reality stresses and is, therefore, a reactive symptom formation.

In a substantial number of cases, the psychoneurotic pattern is a sequel of an unresolved Oedipus situation. In these cases, aggressive behavior may occur to a lesser or greater degree, but the aggression is usually circumscribed and limited to a local situation like the home or school; or it may be expressed in relation to one person or group of persons. The usual development is neurotic symptom formation, which generally overshadows the aggressive

behavior. This can be traced back to the fifth or sixth year of life and is undoubtedly an aspect of the child's failure to solve the Oedipal situation.

In some cases the neurotic pattern is provided by a person with whom the patient had made a close identification. In others, the neurotic symptoms are designed to win the attention and affection that has been denied.

There were 12 cases in this neurotic pattern classification. Of interest are:

Case 5

A. S. is a 19-year-old white girl with an IQ of 71 who reacted to an illegitimate pregnancy, post partum, by presenting mixed psychoneurotic symptoms of anxiety, depression, a host of physical preoccupations and an obsessive, compulsive concern with her appearance and cleanliness, which on TAT analysis appeared to be surface manifestations flowing from strong feelings of guilt and of self-punishment, associated with social stigma and ideas of infanticide.

In her stories, she attempts to erase reality, through overcompensatory, detailed, obsessive and ritualistic conversions of her personality to fit a highly idealized concept of self, which she pictures as a pleasant, attractive, dominant and aggressive female, undefiled and free of evil or contamination, possessed of good taste and wisdom, who is in a safe and secure state where there is little anxiety. When she contrasts her real self with this ideal and discovers that her attempts to achieve this goal are fruitless, feelings of inferiority and inadequacy, failure and aloneness and guilt become intense, and she is left depressed and emotionally exhausted.

Case 6

The case of R. N. is also illustrative of this group. He is a 14-year-old illegitimate offspring of a mentally-defective mother. He presents anxiety in its many forms, and aggressive tendencies toward maternal figures, as the result of having to face many changes of foster homes as a ward of the Department of Social Welfare of Seneca County.

He was committed to Newark State School because of striking his foster mother, starting brush fires and for threatening suicide and stating that life was not worth living.

This TAT protocol reflects mixed emotions because of emotional traumatic material stemming from the confused background of changes of home. A prominent feature is his preoccupation with morbid ideas of destruction which he directs at those who, he feels, have harmed him, and at himself. Acts of aggression are particularly provoked by mother figures. These strong sado-masochistic drives have evoked the significant tendency to withdraw from reality.

R. N. also has strong feelings of rejecton and inferiority which prevent him from attaining desirable goals; and out of these feelings, have emerged distrust, suspicion and greater depression.

Although the writers find no clear identification with significant parental figures, a rigid, moralistic concept is present, generating unconscious guilt and self-punishment.

The sexual area is charged with fear and indicates the presence of castration feelings. This relates to concern over masturbatory practices and their consequences. These are further related to strong feelings of destructive hostility in social relationships and to introjected aggressive desires.

A variety of TAT trends was encountered in the mental defectives with neurotic patterns. The following occurred with greatest frequency:

1. Feelings of inferiority (100 per cent).
2. Strong feelings of anxiety (100 per cent).
3. Guilt feelings in conjunction with past expressions of primitive impulses (75 per cent).
4. A desire to withdraw to a more protected infantile level (66 per cent).
5. A preoccupation with the conflict between good and evil, coupled with a strong desire to comply with the established mores (66 per cent).
6. Oedipal conflicts (50 per cent), coupled with castration fears (60 per cent).
7. Closer identification in adolescent boys with female rather than male figures.

The dynamics of the neuroses seem to determine content. However, the boys were more expansive in expression than the girls and manifested less shock and rejection of cards.

Summary

A survey of the test results of the TAT in all types of mental defectives in this series reveals a number of general themes which appear consistently in their protocols. It is interesting to note that the writers' findings are analogous to those discovered by Sarason[4] in his application of this test to uncomplicated mental defectives.

Foremost in the variety of trends encountered were:

1. An insatiable need for affection and acceptance is present.

2. The aggression released by primitive forces is not sacrificed and diluted by the child, in return for compensatory affection. There is a resultant inadequate super-ego development.

3. Aggression develops further as a means of revolt and revenge against a harsh society which has rejected and ostracized the child and denied the child the opportunities of his equitable share of attention, affection and recognition. These two factors, abandonment by a dubious home environment and rejection by society—which makes the child feel different from others, stigmatizes him and imposes the handicap of even lower intellectual functioning—are conspicuous in practically all of the writer's cases.

4. Feelings of guilt, anxiety, aloneness and insecurity emerge from this situation, with creation of a greater need for protection and security.

5. There is an ambivalence toward all figures, both maternal and paternal, from whom affection and security are sought; and toward whom aggression is aroused when needs for these are frustrated.

6. A depressive tone is noted in most of these cases. It seems to center around a distorted concept of the self and around insecurity, anxiety and uncertainty over future events.

7. In the adolescent girls, a desire for a dependent, submissive role where security and protection are offered, preferably by a mother figure, occurs with great constancy. One would expect these girls, who have had sexual experience and some of whom have even had children, to desire the security of a male figure. Instead they long for the return of the mother-child relationship. The boys, on the other hand, desire maternal affection, but with greater independence.

8. A prominent feature is the idealization of the happy family situation which in effect is a fulfillment of these patients' concealed longing for something they have never had. The older boys assume the father role in these situations, whereas the girls of all ages want to be the children, even creating roles for children where none exist.

9. Although Sarason[4] does not observe the prominence of self-aggression themes in his cases, the writers find this mechanism present in all clinical types.

10. Sibling rivalry is a common theme. Although it has its basis in these patients' own family relationships, it appears to be aggravated by frequent placements in foster homes and in the institutional situation where the affection of mother figures must be distributed among many children.

The IQ seems to have little effect on the content of the stories. The IQ range in the whole group varied between 50 and 88, and the chronological age spread was between eight and 20.

Tables 1 and 2 are presented as a statistical compilation of the data obtained in this study of 50 cases of institutionalized mental defectives with accessory mental reactions.

Conclusions

1. The TAT has been administered to 50 institutionalized mental defectives with atypical mental reactions.

2. It has proved to be a fruitful method of overcoming the resistances of the mental defective, a trying task of great magnitude.

3. The TAT is a valuable provocative and confirmatory instrument in establishing the "personality profile" of the mental defective, a term proposed by Kanner[2] to cover an inventory of the individual reactive patterns in correlation with the various determinants of personality.

4. In dealing with emotional problems of the mental defective, and especially with unconscious factors, the TAT is a valuable instrument for releasing concealed material, thereby offering greater understanding of the individual.

5. The TAT thereby lends support to the contention that the mental defective is a personality.

Table 1. Tabulation of the Trends Revealed in the Entire Group and Their Relative Frequencies

Code No.	Trends	Primary behavior disorder		Psychopathic personality		Schizophrenic type		Neurotic type		Total	
		No.	Per cent	No.	Per cent	No.	Per cent	No.	Per cent	No.	Per cent
1.	Desire for protection and security	10	63	5	42	10	100	12	100	37	74
2.	Guilt feelings	9	56	5	42	10	100	12	100	36	72
3.	Feelings of anxiety and fear	9	56	5	42	7	70	12	100	33	66
4.	Feelings of depression	11	69	6	50	6	60	8	66	31	62
5.	Desire for acceptance and affection	12	75	5	42	4	40	9	75	30	60
6.	Hostility to authority figures	14	88	9	75	3	30	4	33	30	60
7.	Feelings of inferiority	8	50	2	16	7	70	12	100	29	58
8.	Rejection by parents	10	63	9	92	2	20	4	25	27	54
9.	Feeling of aloneness	6	38	8	67	6	60	5	42	26	52
10.	Inadequate super-ego development	9	56	12	100	2	20	3	25	26	52
11.	Repressed aggression	6	38	4	33	6	60	10	83	26	52
12.	Aggression	10	63	6	50	3	30	5	42	25	50
13.	Desire to withdraw	4	25	2	16	10	100	8	66	24	48
14.	Internalized aggression	4	25	3	25	8	80	8	67	23	46
15.	Feelings of frustration	6	38	6	50	3	30	7	58	22	44
16.	Sibling rivalry	8	50	3	25	3	30	6	50	20	40
17.	Fantasying ideal situations	8	50	2	16	3	30	7	58	20	40
18.	Oedipal conflict	5	31	2	16	6	60	5	42	18	36
19.	Idealizing the identification figure	4	25	7	58	1	10	3	25	15	30
20.	Morbid content	2	13	1	8	6	60	5	50	14	28

Figure 2. Individual Breakdown of the 50 Cases Studied

Case No.	Sex	Age	Family back-gound*	Behavioral pattern	IQ	Trends by code number
1.	F	11	+4	Prim. behav. dis.	61	5, 6, 8, 10, 12, 14, 16, 17, 18
2.	M	11	+3	Prim. behav. dis.	79	1, 2, 3, 4, 5, 6, 7, 10, 16, 18
3.	M	12	+4	Prim. behav. dis.	78	2, 4, 5, 6, 7, 8, 10, 12, 18
4.	M	15	+3	Prim. behav. dis.	72	2, 3, 4, 5, 6, 7, 8, 10, 11, 14, 18
5.	F	8	+2	Prim. behav. dis.	88	1, 2, 5, 6, 8, 10, 11, 18
6.	F	9	+4	Prim. behav. dis.	71	1, 5, 6, 8, 10, 12, 13, 16
7.	F	15	+3	Prim. behav. dis.	66	2, 3, 4, 5, 6, 7, 8, 11, 16
8.	M	14	+3	Prim. behav. dis.	60	1, 2, 3, 4, 8, 10, 11
9.	F	19	+4	Prim. behav. dis.	72	1, 5, 6, 14, 15
10.	M	16	+4	Prim. behav. dis.	71	1, 3, 4, 5, 6, 7, 8
11.	F	10	+4	Prim. behav. dis.	71	1, 5, 8, 11, 12, 16, 17, 19
12.	F	13	+4	Prim. behav. dis.	51	4, 5, 6, 11, 13, 15
13.	M	17	+4	Prim. behav. dis.	60	1, 3, 4, 6, 7, 14, 17, 19
14.	F	13	+4	Prim. behav. dis.	65	3, 4, 6, 9, 10, 12, 20
15.	M	15	+4	Prim. behav. dis.	68	1, 2, 5, 6, 7, 8, 9
16.	F	15	+4	Prim. behav. dis.	69	1, 2, 3, 5, 6, 9, 15, 19
17.	M	19	+3	Psycho. person.	52	8, 10, 12, 14, 17
18.	M	18	+3	Psycho. person.	69	2, 3, 4, 5, 6, 7, 8, 10, 14
19.	M	14	+3	Psycho. person.	78	1, 2, 4, 6, 7, 8, 9, 10
20.	F	14	+4	Psycho. person.	79	5, 7, 8, 9, 10, 12, 15
21.	F	17	+1	Psycho. person.	73	4, 7, 9, 10, 11, 15
22.	M	19	+4	Psycho. person.	59	1, 5, 6, 8, 10, 14, 15
23.	M	17	+2	Psycho. person.	65	1, 2, 3, 5, 6, 7, 8, 10, 11, 13, 16
24.	F	19	+4	Psycho. person.	78	2, 9, 10, 11, 14, 20
25.	M	15	+3	Psycho. person.	51	1, 4, 5, 6, 8, 10, 18
26.	M	16	+3	Psycho. person.	80	1, 5, 6, 8, 9, 10, 12, 18
27.	M	14	+3	Psycho. person.	86	1, 2, 8, 9, 10, 15, 19
28.	M	20	+2	Psycho. person.	78	1, 2, 5, 6, 8, 9, 10
29.	F	10	+4	Schizophren. type	60	1, 2, 3, 5, 7, 8, 11, 14, 20
30.	M	16	+2	Schizophren. type	74	1, 2, 3, 7, 11, 13, 16, 18
31.	F	12	+3	Schizophren. type	56	1, 2, 4, 7, 11, 13
32.	F	10	+1	Schizophren. type	53	1, 2, 11, 12, 13, 14
33.	F	14	+4	Schizophren. type	63	1, 2, 4, 6, 7, 11, 13, 14
34.	M	7	+2	Schizophren. type	87	1, 2, 4, 6, 7, 8, 10, 12, 13, 16, 18
35.	F	13	+4	Schizophren. type	54	1, 2, 3, 5, 8, 12
36.	M	7	+1	Schizophren. type	75	1, 2, 3, 5, 9, 11, 12, 13, 16
37.	F	17	+2	Schizophren. type	80	1, 2, 3, 4, 5, 11, 18
38.	M	8	+4	Schizophren. type	71	1, 2, 10, 12, 13, 14
39.	M	11	+3	Neurotic type	60	1, 2, 3, 5, 8, 10, 14
40.	M	14	+4	Neurotic type	78	1, 2, 3, 5, 6, 7, 14, 16

*Evaluation of family backgrounds in terms of degrees of unwholesomeness in ascending numerical order.

Table 2. Individual Breakdown of the 50 Cases Studied—(Concluded)

Case No.	Sex	Age	Family background*	Behavioral pattern	IQ	Trends by code number
41.	F	13	+4	Neurotic type	58	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 14
42.	M	17	+2	Neurotic type	76	1, 2, 3, 4, 5, 7, 8, 11, 16
43.	M	18	+3	Neurotic type	74	1, 2, 3, 4, 7, 10, 11
44.	M	11	+4	Neurotic type	87	1, 2, 3, 7, 11, 13, 14, 18
45.	F	19	+2	Neurotic type	71	1, 2, 3, 5, 7, 13, 15, 16
46.	M	7	+4	Neurotic type	71	1, 2, 3, 4, 5, 7, 11, 12
47.	M	15	+3	Neurotic type	75	1, 2, 3, 6, 7, 11, 13, 14
48.	F	19	+4	Neurotic type	64	1, 2, 3, 7, 17, 18
49.	F	14	+1	Neurotic type	51	1, 2, 3, 4, 6, 7, 11, 15, 16
50.	F	15	+4	Neurotic type	84	1, 2, 3, 4, 5, 6, 7, 11, 12, 13, 14, 16

*Evaluation of family backgrounds in terms of degrees of unwholesomeness in ascending numerical order.

6. In conclusion, the TAT aids in the clarification of diagnoses, the comprehension of dynamics and the facilitation of treatment of mental defectives.

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PSYCHOLOGICAL FACTORS IN THE PRODUCTION OF PARESTHESIAS FOLLOWING THE SELF-ADMINISTRATION OF CODEINE: A CASE REPORT*

BY GEORGE DEVEREUX, Ph.D.

The writer proposes to describe an instance of multiple paresthesias, accidentally induced by the self-administration of ¾ gr. of codeine taken as a hypnotic. These paresthesias are of special interest, for several reasons:

1. They were the result of the self-administration of a relatively moderate dose so that their occurrence could not be accounted for merely in pharmacodynamic terms, in a subject not hypersensitive to codeine.
2. The form, range and intensity of the paresthesias appear to have been detemined by the day-residue.
3. One of the "paresthesias" actually simply restored a normal psychological function, which had been impaired by the repression of the primal scene.
4. The genuine paresthesias were of a type which shed some light upon the nature of fantasy in schizophrenia, in that they consisted of a reorganization of the sense-impressions in accordance with subjective needs.

The Data

The following data were obtained several years ago from a young psychologist, who desires to be unidentified.

On a certain Sunday the subject awoke rather late. After lunching with his wife, who was also a psychologist, both of them spent the afternoon reading a manuscript of the present writer's which dealt with the problem of paresthesias in the formation of fantasy; and, having become interested in the subject, also looked up several of Angyal's papers[1] to which reference was made in the manuscript. They had supper out at 5:30 p. m. and then went home and read. At 9:30 both became hungry again, went out for a "light snack," and returned home at 10:30. At that time, the subject began to wonder whether, because of the fact that he had slept until noon, he would be able to fall asleep at once, and thus have a full night's sleep. For this reason he decided to take a hypnotic or

*From Winter Veterans Administration Hospital, Topeka, Kan.

sedative, but found that all he had available were some codeine tablets, which had been given to him some months previously, when he had had an exceedingly painful sinusitis and a hacking cough. Since he did not know the proper dosage, he took ¾ gr., in the form of three ¼ gr. tablets, and then went to bed.

Upon going to bed he placed himself in his usual sleeping posture: He lay on his right side, the bent right arm thrust under the pillow, the upper part of the left arm against his chest, the left forearm turned slightly at the elbow, the palm resting on the bed. A few minutes later he thought he was about to fall asleep. He felt a slight oscillatory movement of his body—recalling the oscillations of the needle of a compass—the fixed point of which was the abdominal region. He sometimes experienced this feeling when he felt rather tired, and was about to fall asleep.

Perhaps 20 minutes were spent in this relaxed posture, when gradually his head began to clear, and he realized that he would not go to sleep within the next hour. Although such a prospect usually annoys him, it left him indifferent on this occasion. Suddenly he became aware of the fact that his face, from the nasion downward, was becoming "wooden." He recognized this feeling as similar to the sensation which he experiences on the very rare occasions when he takes more than a single drink. His face also felt extremely heavy, but did not seem to "push" harder than usual against the pillow. On compressing his jaws, the alveolar pressure was felt to be "rubbery." The subject realized that he had experienced this feeling on at least one previous occasion, which, for some obscure reason, he associated with his adolescence. The attempt to assign a date to the first experience of this sensation required considerable meditation.

Next, the subject noted a similar feeling of weight in his hands. He felt reasonably certain, however, that his hands had not "gone to sleep," since he was thoroughly familiar with the feeling of having his hands or limbs "fall asleep." Because of the contorted way in which he usually sits, this "falling asleep" of a limb happens to him rather often.

In connection with the experience of facial "heaviness," the subject mentioned a visual imagery which "corresponded" to this experience. It should be noted that he specified that, in experiencing this "heaviness," he felt no increased pressure against the pillow. Rather, the feeling was as if the zygomatic arch of his right cheek

functioned as the fulcrum of a balance composed, on the one side, of his face, and, on the other side, of his skull, which acted as a counterpoise to the weight of his face. At the same instant he also began to visualize a cube of wood, on which lay, on one of its sides, and with its base toward him, a low rhombic prism. The edges of this base were white, forming a parallelogram of forces, while the rest of the base was sky-blue, i. e., the same color as the façade of a certain restaurant, which he also visualized, but perhaps an hour later. It is noteworthy that the subject "knew" that it was a relatively low prism, although he saw only its base. It is also interesting that the half of the rhombic prism which, in his belief, "corresponded" to his face was in contact with the block on which it rested, while the half "corresponding" to his skull was not. (It might be added in this context that the subject had recently inspected a fine collection of models of three-dimensional geometrical figures.)

The sensation of weight in the hands was not experienced as a further increase in the pressure of the hand against the bedsheet. He attributed this sensation to a relaxation of the muscular tension which normally compensates for the influence which the force of gravitation exerts upon the body.

Because of his current interest in paresthesias, the subject decided to devote the sleepless time to self-observations. He first tested his cutaneous sensitivity, by pinching various parts of his body with his fingernails. Although he exerted a rather hard pressure, he did not experience any sharply localized sensation, such as one associates with pressure by a sharp point. The external surfaces of his calves (which show a slight atrophy of the peroneal nerve) were especially insensitive. Only when pinching his own finger tips did he experience a sensation of sharpness. In all other places, the pinched flesh felt rubbery and soft to his fingers.

On discovering that his wife was awake, he asked her to cooperate in this test, because he felt that his muscle-tonus might have decreased to the point of rendering adequate pressure impossible. This suspicion was not validated, since, even when his wife pinched him, he still found that his cutaneous sensitivity had greatly diminished.

When he intended, or prepared, to move, he could, without moving, actually feel the jar of the movement. However, when he actually did move, no such foresensation was experienced.

At this point, the subject began to be aware of certain visual distortions. Thus, on turning on the light, he thought that his wife's rather thin face seemed somewhat broader than usual. This pleased him, since he had often thought that his wife was somewhat too thin. Contrariwise, his own rather bony hands, which he would have liked slenderer, seemed so thin that his fingers did not appear to be thicker than ordinary fountain pens. The round alarm clock appeared slightly elliptical, as if it had been compressed laterally. At first he thought that this impression could be accounted for by the fact that the clock had a low pedestal. In reply to a direct question, the subject's wife told him, however, that the presence of the small pedestal did not prevent *her* from perceiving the face of the clock as perfectly circular.

Next, the subject attempted to test his hand-eye co-ordination. He asked his wife to place one of her cigarettes on her night-table, so that he could try to touch it by means of a rather rapid forward thrust of his right index finger. This experiment was somewhat delayed, because the subject's attention was absorbed by the fact that the cigarette seemed unduly short to him. He thought that this visual illusion might have been due to the fact that it was a regular-sized Philip Morris cigarette, while the subject himself usually smoked long Tareyton cigarettes. It should be noted that he did not realize at once that he was looking at a Philip Morris, because, for the last few days, his wife too had switched to long Tareytons. Even after the subject had realized that it was a Philip Morris, the cigarette still seemed too short. In this context, he mentioned that a few days earlier he had observed a similar disturbance in his capacity to organize size-relations, when, after reading a triple-spaced typescript, he had had to switch to a double-spaced one, whose lines then seemed to be *abnormally* close together.

The hand-eye co-ordination experiment gave poor results, the subject missing the cigarette several times with his index finger, although normally his hand-eye co-ordination is better than average.

Shortly thereafter, on touching his wife's forearm, he suddenly realized that his actual experience of her skin texture was psychologically far less "plausible" than the simultaneously experienced *imaginary experience* of touching her forearm.

By this time, his wife also had begun to take an intensive interest in the experiment, and suggested that she test the subject's ticklishness. Although he is ordinarily exceedingly ticklish, on this occasion all of her efforts to evoke a spasm, by tickling him, failed completely. The tickling merely yielded a sensation of diffuse and rather pleasant contact, although normally a similar attempt would have left the subject convulsed, and almost helpless with laughter.

Last of all, the subject asked his wife to check the rapidity of his finger-movements, while he pretended to play the piano on the bedsheet. The sheet felt fluffy and almost airy under his fingers There was no real sense of contact, although the subject's fingers are rather strong from playing the piano and from doing a great deal of typing. His wife assured him that his finger-movements were very rapid, although he himself had thought that his trill and tremolo movements were rather slow on this occasion.

Next, the lights were put out, and the subject went back to bed. On lying down, he began to try to interpret these sensations, and especially the sensation that the imagining of things was a more plausible experience than the actual act of seeing or touching them. While trying to analyze this, he realized that his thought-processes were extremely clear and orderly, but felt that they did not rise to any abstract heights.

This, needless to say, is rather noteworthy, since opiates generally produce a feeling of unusual intellectual creativeness. The absence of this illusion of brilliance may be due to the fact that the subject's intellectuality was not inhibited, and was his chief defense mechanism. (This, in turn, may explain why he is practically a teetotaller, and usually also abstains from sedatives and hypnotics.)

In retrospect the subject felt that he might have underestimated his capacity for creative thought, simply because he had accepted the present writer's theory of paresthesias, which *fitted his own current experiences so perfectly* that he felt no need for another explanation. This, in turn, suggests that the theory played the role of a day-residue in the formation of his paresthesias, and that the codeine could have acted merely as a trigger-mechanism. It should also be noted that the feeling of decreased intellectual competence was already interpreted by the subject as caused by his acceptance of the writer's ideas regarding paresthesias. This does

not prove, however, that, had he found this theory of paresthesias inacceptable, he could have produced an original explanation of his experience *at that time*. On the other hand, his need to *state* that he might have underestimated his intellectual performance, as well as his general intellectualistic orientation, suggest that his narcissistic intellectual megalomania had led to an ego-syntonic reaction-formation, in the form of a megalomaniacally-heightened level of aspiration.

In bed with the lights out, the subject turned from considering his thought-processes to consider the problem of the unusual vividness of his imagination and visual imagery. In this context he mentioned that even though he had a rather unusual visual and spatial memory—citing several "feats" in support of this statement—he usually had no *true* visual *imagery,* and could not actually *visualize* the things which he could *describe* in such detail. He also stated that he usually lacked eidetic imagery.

Since, at that time, the subject did experience intensive visual imagery, he attempted to test it, by seeking to re-experience certain situations in which he had found himself in the past. Since he had recently had occasion to think a great deal about San Francisco, he was not in the least surprised when he suddenly saw with extreme vividness the last corner of a street which ends near the San Francisco ferry building. He stated that he could even *see* the corner stones, clearly outlined and silver-gray, of the last house of that street. This is interesting, since he did not know San Francisco very well, and had been in that particular district only twice.

Next, the subject saw very sharply, and with great plausibility, the light-blue façade of a certain French restaurant in San Francisco. Although he did not recall ever having been in the restaurant, he could visualize even the individual leaves of the potted shrubs which separated the tables from the sidewalks. It should be noted that both this restaurant and the district near the ferry building had played minor roles in a fairly important episode of his life, some six years earlier.

Next, the subject *saw* the smallest drawing room in the house of a Boston society woman. It was the room in which she had first received him some 12 years earlier. Later on, this woman had the wall between this room and the adjoining dining room broken down, and the subject recalled that he had disliked this change at

that time. He could visualize very clearly both the small room, and the lady in question, who seemed to wear a brown tailored suit, and a bronze blouse. However, the color of the visualized blouse disturbed him, because he recalled objectively that she had never worn anything but white blouses with that particular two-piece suit. In the next instant, he realized that the blouse *was* white, and that he actually *"saw"* it as white. At the same time, he noted that the armchairs in the drawing room had turned from brown, as he had first visualized them, into a rich bronze, which, as he now recalled, had, indeed, been their real color. However, the armchairs apparently could not assume their proper color (which also dominated that drawing-room), until the *blouse* was at last perceived in *its* proper color. In this instance, the visualization of the color-object relationship had been disturbed, until objective reasoning, i. e., the cortical organization of sense-data. restored the bronze to the chairs to which it had belonged originally. This point is significant, if one defines delusions and fantasy as skewed ways of organizing reality.

Subsequently, a number of other pictures were also visualized, including such images as human faces and bodies, which, as a rule, the subject has some difficulty in evoking with any degree of plausibility. In every case, he was struck by the great vividness of his imaginary experiences, which exceeded in intensity both somatic sensations, and stimuli emanating from his immediate surroundings, such as the siren of a passing police car, the touch of the bedsheets, etc.

The subject then began to consider whether he merely *thought* that these re-experiences were more vivid than usual, or whether the diminution of somatic and immediate sensations, which might have been due to the codeine, actually increased the plastic and other qualities of memory images.

Interpretation

In psychoanalytic terms, this experience of the *intensity* of imaginary and visualization experiences may be explained as follows: Granting the hypothesis that the amount of libido available for cathexes is, at any moment, limited, the decreased cathecting of somatic and environmental stimuli appears to permit an increase in the cathecting of fantasy—leading to an increase in the intensity and vividness of fantasy. However, the problem can also be use-

fully investigated in terms of Hughlings Jackson's theory, by asking whether the intensity of imaginary experiences was caused by the *liberation* of inhibited functions, or was *primarily* symptomatic of the *dissolution* of higher and more critical functions. Psychoanalytic interpretations lead to the conclusion that, whereas the *fact* or *act* of fantasying is primarily a *negative* symptom, i. e., one due to the dissolution of the critical, inhibitory functions, the *content,* and, *a fortiori,* the *intensity* of the fantasy experiences are primarily *positive* symptoms, i. e., due to the liberation of previously inhibited functions. This view is fully compatible, both with psychoanalytic metapsychology, and with what is known of the relationship between schizophrenic withdrawal and fantasy life.

As regards the events under consideration, Jackson's theory sheds a great deal of light, especially upon the mechanisms responsible for the occurrence of visual imagery. It has already been noted that the subject's capacity for visualization was, as a rule, practically nil, the visualization of faces and of nude bodies being altogether an impossibility for him. An indication of the nature of this inhibition is to be found in the fact that, on this occasion, the appearance of visual imagery was preceded by fantasied oscillatory movements. According to Fenichel,[2] this inner experience also occurs when, in the course of analysis, repressed memory-traces pertaining to the primal scene are about to become conscious. It is also to be noted that a subsequent therapeutic analysis of this subject removed this inhibition, by interpreting its relationship to the primal scene. Hence, it seems legitimate to suggest that the subject's capacity for visualization was inhibited in order to prevent the emergence of visual images pertaining to the primal scene, which would have brought about the re-experiencing of an almost unendurable sexual excitement and aggressiveness.[3]

At this juncture it should be pointed out that, except for the leaves and for the building at the San Francisco quay, the subject had, thus far, mentioned only imagery which he could, at any time, recall at will and in detail—though nonvisually—that is, in a purely objective manner. There were also, however, other memory-images, whose validity the subject was unable to confirm by means of objective memories. Thus, the subject did not possess a set of organized and consciously familiar memory-data, which

could have enabled him to confirm that the actual pattern of the curtains in his former St. Louis apartment was indeed identical with the pattern which he could visualize on this occasion, or "see" at close range, thread by thread, merely by wishing to do so. Consequently, because of the absence of confirmatory conscious memories, the *details* of visualized objects, such as the curtain pattern, the definite spatial location of the individual leaves of the potted shrubs, etc., must, psychologically at least, be considered as "fill-ins," *quite regardless of their truth or falsity.* On the other hand, the color of the armchairs was something of which he was certain at all times, witness his discomfort on "seeing" their color displaced to the blouse.

It need hardly be pointed out that the genuine "fill-ins," as well as the correction of the color originally ascribed to the blouse, were due to the need to complete an incomplete *Gestalt* possessed of *Prägnanz.* The genuine fill-ins, whose correctness could neither be verified by "objective" memory, nor challenged logically as not being system-adequate, belong to the type of "closure" which the writer has described elsewhere as "neurotic," while the correction of the color of the blouse, *which brought emotional relief,* is comparable to the mature, system-adequate closure of a *Gestalt,* brought about by a correct, effective and timely psychoanalytic interpretation.[4]

The subject's general withdrawal—i. e., the de-cathecting of outlying ego-boundaries—was also accompanied by nonvoluntary effects. When he noted that his breathing was shallow and purely abdominal, the following experiment was tried: He inhaled, counting up to 10. He then held his breath, counting up to 10. Next he exhaled, counting up to 10, and then held his breath, counting up to 10, etc. Counting was done slowly, and was synchronized with a very slow pulsation, felt in the left side of the neck, near the larynx, which, in turn, was synchronic with pulsations in the lower left side of the thorax. Although counting seemed rather slow during the periods when he held his breath, and also in the last stages of exhaling, no acute need for air was felt. On repeating the same experiment the next morning, the subject felt no pulsations, nor could the experiment be carried out, even in a relaxed posture, without experiencing acute discomfort and need for air.

These data, needless to say, fully confirm Angyal, Freeman and Hoskins' observations on physiologic withdrawal in schizophrenia.[5]

Summary

The self-administration of ¾ gr. of codeine, taken orally as a hypnotic, produced, approximately an hour after its administration, a partial cutaneous anesthesia, and numerous paresthesias, which led to a skewing in the organization of sense-impressions emanating from the environment. The organization of immediate experiences during this period was dominated by the then predominant organic-somatic paresthesias, by decreased hand-eye coordination, and by the perception of objects in incorrect forms, dimensions and spatial relations.

Next came a great deal of visual imagery which, while neither unusual nor brilliant, was, nonetheless, more plausible than were the subject's usual attempts at visualization, and approximated eidetic imagery. During the predominantly visual period, somatic sensations and paresthesias dwindled almost to nothing. Stimuli emanating from the external environment were incorporated into the visual imagery, and they organized the latter into a consistent pattern.

A general decrease in the responsiveness on all levels can be inferred from indirect data. The imagery was in every way more plastic and plausible than reality. Objects touched seemed less "real" than the same objects when touch was merely imagined, and imagined movements were felt more than actual ones. The higher functions were unimpaired, and speech was normal, though somewhat slower than the subject's usual tempo of verbal output.

The entire experience was radically influenced by an intellectual "day-residue," i. e., by the reading of a manuscript dealing with the relationship between paresthesias and fantasy, especially in schizophrenia.

The first part of the experience was characterized by the presence of numerous and rather commonplace paresthesias, culminating in the distortion of visually perceived objects, and in the observation that fantasied movements and experiences seemed psychologically more vivid and plausible than actual movements, contacts, and sights.

At this stage there occurred a great deal of visual imagery pertaining to past experiences. Part of these visual images could be *verified* by "objective" recall, part of them could be *corrected* by "objective" recall, and part of them must be viewed as *"fill-ins,"* regardless of whether or not they were objectively accurate.

The intensity of the visual imagery and of fantasy was due to a de-cathecting of certain ego-boundaries, and especially of bodily and sensory boundaries, which had been disturbed by the paresthesias produced by the ingestion of codeine. Thus, in terms of Jacksonian nomenclature, only the initial paresthesias can be viewed as "negative symptoms" caused by a dissolution of higher functions, and by a de-cathecting of the ego-boundaries. The content, and affective intensity and plausibility, of the fantasy-material and of visual imagery were, on the other hand, "positive symptoms," liberated by the dissolution of critical faculties. This inference is confirmed by the fact that a subsequent psychoanalysis restored the subject's capacity of visualization, which had formerly been able to express itself only in an unsual, though *non-visual,* capacity for the intellectual recall of the form of objects and their spatial relationships.

The subject's tendency to use "fill-ins" exemplifies the need for a neurotic closure of a *Gestalt,* when inhibitions, or the natural limitations of memory, make a mature and system-adequate closure impossible. The correcting of an initially distorted visual memory, which was accompanied by a sense of relief from tension, exemplifies the therapeutic effectiveness of correct and timely analytic interpretations which, as pointed out elsewhere,[4] change the neurotic closure of a *Gestalt* into a system-adequate and ego-syntonic one.

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THE CONFUSIONIST—A NEGLECTED NEUROTIC TYPE

BY EDMUND BERGLER, M. D.

In the face of opposition he [Charles Sumner] would support his theories with formidable citations from history, law, economics, belles-lettres, anthropology, chemistry and religion. He would quote Spinoza and the Boston Cooking School in the same breath. But he rarely, if ever cited common sense.

WILLIAM E. WOODWARD: *Meet General Grant,* Chapter 25, Part 2.

The opposite of the familiar type, the person who can "think" only according to his individual assortment of pigeonholes, is another neurotic subdivision, comprising individuals who mix *all* pigeonholes together. Members of the former type think in static terms; members of the latter, in confused terms. The language does not possess a noun to describe an individual who is unable to compartment his thoughts; what comes nearest to filling the need is the popular designation, "a confused person." The suggested neologism, "neurotic confusionist," may seem clumsy and may not be precisely the King's English, but at least it points to a well-known and observable type. There is an obvious objection to the term: Words ending in "ist" frequently denote frantic activity, as in Fascist, Communist, collaborationist; there are, however, "ists" of a more contemplative nature, such as optimist, pessimist, etc. Viennese dialect, in Franz Joseph's time, was enriched by the creation of an ironic term to describe the man of confused thinking. This term was *"Confusions-Rat,"* (*Counselor of Confusion*), an untranslatable allusion to the tendency of showing off with meaningless titles, like "Imperial Counselor" (*Kaiserlicher Rat*), or "Imperial Counselor of Commerce" (*Kommercial Rat*).

At first, the confusionist impresses one as a conclusive demonstration of the inefficiency of reasoning in general; he seems to confirm Luther's opinion, "Human reason is like a drunken man on horseback; set it up on one side, and it tumbles over on the other." Perhaps Voltaire's observation was more than an aphorism: "Many are destined to reason wrongly; others, not to reason at all; and others, to persecute those who do reason."

Phenomenologically, the confusionist is an amazing fellow; his mental legerdemain transforms the simplest thing into a confused problem, and the most complicated matter into a simplified but no less confused affair. His is the ability to create an "air of confusion," mostly by clouding the issue with unrelated "ideas." If a confusionist is discussing prostate troubles, Polynesian birds will suddenly make their appearance in his remarks; unconsciously the confusionist will have made sure that a specialist in Polynesian birds is present to prove to him (a) that the bird he is referring to has no relation to prostate troubles, and (b) that the outlandish bird he has allegedly seen was really an English sparrow. To which the confusionist's reply will be a reference to Dutch cheese. In short, you cannot win with a confusionist.

A variety of stage properties make up the external technique of the neurotic confusionist.* According to these props, the confusionist type may be subdivided as follows:

First, the *specialist in misunderstanding.* Very soon it becomes clear that the argument promoted by you has been fantastically misunderstood by the confusionist. When you try to correct the misconception, you are reproached for your inability to express yourself precisely. Then you are presented with a second edition of the original mistake, or with a brand new misunderstanding. And so on, without any hope of clarification.

Second, the *promoter of his own pet ideas.* Here the confusionist uses the other person's statements merely as vehicles for the repetition, *ad nauseam,* of his favorite and presumably only idea. The hobbyhorse is saddled and spurred until it gallops. This technique is ridiculed in the joke about the zoologist whose pets happened to be flies: a pupil, asked at an oral examination to describe an elephant, replied: "An elephant is a big animal, so big that flies frequently gather on his back; flies are in general subdivided . . ."

Third, the *quotation-specialist.* The starting point is a quite rational aim, couched in a confused argument, and bolstered with quotations ranging from "Spinoza to the Boston Cooking School," these quotations brought forward in rapid succession. The quotation from Woodward, the introductory motto of this paper, refers to this. Elsewhere in *Meet General Grant* one reads of "The Turmoil of Reconstruction" after the Civil War:

*Psychotic cases are excluded in this paper.

"Charles Sumner, who declares that he has studied everything on the nature of republics from Plato to John Marshall, contended that the seceded states have committed suicide. That seems incredible, for obviously the Southern people still exist and have elected complete state governments. But that means nothing to Sumner. So he talks of wholesale suicide, and one gets an unpleasant impression that there are dead bodies lying around the house. Mr. Sumner, who leads the Radicals in the Senate, is ready to turn himself into a coroner . . . . . Sumner's views were implacable and statuesque. When he once adopted an idea he never let it go. . . . There was another motive in these maneuvers. . . . Before the war each slave, in accordance with Article I of the Constitution, was counted as three-fifths of a person when the periodical enumerations were made for the purpose of determining how many representatives a state was entitled to in Congress. But now the Negroes were free, although they were not allowed to vote, and each Negro had to be counted as a whole person. The result would be an increased representation from all the Southern states, in short, the South would be stronger in Congress than it had been before the war. . . ."

For present purposes, it is immaterial to consider whether Woodward's Southern sympathies affected his judgment of Sumner's drastic proposals for the "reconstruction" of the South. The type described, and rightly or wrongly attributed to Sumner, does exist.

Fourth, *the logorrhoeic type, who gets confused during his own deduction.* The starting point is circumlocution. The next step is digression. (For instance, a logorrhoeic at the dinner table might begin with a remark on the quality of the potatoes served, proceed to relate the history of the cultivated potato, and arrive at a discussion of the socio-economic value of this vegetable.) The finale is the impression that the talker does not know what he is talking about. André Maurois' observation is pertinent: "The difficult part in argument is not to defend one's opinion, but rather to know it."

Fifth, *the confusionist with preconceived notions.* Paradigmatic are speakers on subjects announced in advance, discussants of lectures, for example. After reading the announcement, this type of person prepares his remarks to follow the lecture on the basis of free associations. During the lecture, he doesn't even listen; the

lecturer, to him, is an interloper and a nuisance, delaying his delivery of his prepared tale. The inevitable result is that lecture and discussion are totally unrelated, that the "discussion" goes on on a tangent. In one such case, the writer suggested that the discussion *precede* the lecture, since it was entirely irrelevant to the topic of the lecture.

Sixth, *the transformer of periphery to center.* Paradigm: Question: "What time is it?" Answer: "Friday."

In James T. Farrell's short story, *A Misunderstanding* (in the collection *An American Dream Girl,* Vanguard, 1950), a woman of this type is depicted:

"For instance—I [the husband] would come home from the office, and I would think that I am going to have a nice, quiet evening, and Molly and I would have a talk, and we would relax, and, well, we would enjoy our home and our life together. And so I would come home and give her a kiss, and I would say something like:

" 'Hello, dear how are you? Did you have a nice day?

" 'I'll have to try a different kind of soap. I don't like this Sudsy-Suds I've been using.'

" 'But did you have a nice day, Molly?'

" 'There wasn't any mail, dear.'

" 'But I didn't ask about the mail, Molly dear. Did you have a nice day?'

" 'I think there's a new mailman, and he might have made some mistake and put our mail in somebody else's box.'

" 'But, Molly, what kind of a day did you have?'

" 'Oh,' she would exclaim. . . ."

For their twentieth anniversary, the husband buys her a small diamond ring:

"Anyway, I kissed her when I got home and, after making a fuss and being a little mysterious, I gave her the ring.

" 'I got a new brand of olive oil,' she says, looking at the ring.

" 'Do you know what it is?'

" 'Last Monday was a scorcher, wasn't it, dear,' she says, and that was her way of answering my question by telling me that it was Monday.

"I felt sunk, I was so let down. So I told her it was our anniversary, and she told me that the landlord's daughter was engaged to be married.

" 'Do you like the ring, Molly old girl?' I asked her.

"'The landlord's daughter is getting a diamond engagement ring.'

"'This is a diamond. Look at the way it shines. Isn't it pretty?'

"'But I saw the nicest rug today. I was shopping.'

"'But what do you think of that little sparkler, Molly?

"'Oh, when I was a little girl, I loved sparklers on the Fourth of July.'

"So it goes on like this."

Seventh, *the type which confounds different layers of conscious "reasons."* J. Pierpont Morgan said, "A man has two reasons for doing anything—a good reason and the real reason." The financier alluded to *conscious* concealment. In inner reality, the story is even more complicated, because the third and decisive reason—the unconscious one—lies below the surface. In any case, when the different excuses on the conscious level are mixed up, the answers, of necessity, become confused as well. To keep these apart is not so easy. The danger of getting one's own excuses (because of inner guilt) confounded is just as great as the danger of getting mixed up in the wrong daydream, to cite Charles Yale Harrison's fine irony in *Meet Me on the Barricades.*

Eighth, *the specialist in simplification and negation of the unconscious.* As H. L. Mencken has it, "There is always a well-known solution to every human problem—neat, plausible and wrong." The technique is based on overlooking, being unfamiliar with, or negating unconscious motivations.

Ninth, *the pseudo-mental-deficiency type.* The prefix "pseudo" alludes exclusively to the possibility of cure through psychoanalytic psychiatry; otherwise there is nothing pseudo about these half-morons. The problem has been dealt with in the writer's publications concerning this peculiar neurotic disease.*

Tenth, *the "thinker" in false analogies.* The technique consists of *schematic* applications of past events to the present, with free disregard of the differing external and internal circumstances. The case of Lincoln's dismissal of General McClellan is not directly applicable to Truman's dismissal of MacArthur. And so on.

Eleventh, *the "humorous" approach specialist.* Some naïve people believe that cracking a joke, in *any* situation, automatically propels them into the ranks of the intellectual elite. Quite the re-

*"'The Problem of Pseudo-Mental Deficiency.'" Int. Z. f. Psychoan., 18:528-538, 1932. Summary in *The Basic Neurosis* (Grune & Stratton, New York, 1949), pp. 197-201.

verse is frequently observable, and Voltaire stated the case succintly, "Jesting is frequently an evidence of poverty of the understanding." This applies especially to situations in which the crux of the matter is overlooked, and the irony is directed against an unrelated or unimportant detail.

Twelfth, *the creator of artificial confusion for the conscious purpose of avoiding the issue.* This banal technique is best exemplified by the wife who comes to the theater half an hour too late, and parries her husband's reproaches with the classical dictum, "You cannot talk this way to a lady."

* * *

Even these few samples of the different techniques employed indicate that uniformity is by no means to be expected of the neurotic confusionist. Each subdivision may have a specific genetic base. In a short paper, no attempt can be made to trace each subdivision. It will suffice to enumerate two basic unconscious mechanisms which underlie *all* subdivisions, and to which further, and differing, unconscious mechanisms are added according to type.

In the writer's opinion, the two unconscious mechanisms are: first, the tendency *to reduce to absurdity educational authorities* incompletely assimilated in the inner conscience (super-ego); and second, the fact that the *pseudo-aggression* displayed is but a more superficial (though also repressed) *defense against more deeply repressed psychic masochistic solutions of the early infantile conflict.*

The neurotic confusionist misuses the intellectual sphere for his unfinished "battle of the conscience." What at first glance seems to be poor intellectual endowment is in actuality a pseudo-aggressive attempt to alibi oneself before the inner judge, who charges (quite justly) that there exists an unsolved psychic masochistic attachment to the images of the nursery.

This, in turn, constitutes a clue to another of the confusionist's patterns: the frequency with which he makes a fool of himself in public. Exhibitionistically, he displays what he wishes to ward off: his unconscious gluttony for defeat, humiliation, rejection. More superficially, of course, would-be aggression is employed. Since the aggression is spurious, and the underlying psychic masochism quite firm, the results are foreseeable: The firmer tendency wins out.

The pseudo-aggressive argument, therefore, is fashioned in a manner which insures its refutation. It is by no means the confusionist's "stupidity" which leads him to choose an argument that is easily proved wrong; the poor argument is selected "unconsciously on purpose" *because* of its weakness. If defeat is the confusionist's inner aim, this is nothing to marvel at.

To exemplify: A patient, a shrewd and witty intellectual, played the "I don't get you" and "Now, I get you" game for a long time in his analysis. His ability to fail to understand the simplest statements was remarkable. Behind this poverty of understanding was hidden bitter irony, originally directed against his mother. Even for ironically misunderstanding, as he did, the grasping of the essential was necessary. Patiently, his *reductio ad absurdum* technique was explained in the transference, and was proved to be would-be aggression. One day the patient informed the writer that he had finally understood what the writer was trying to explain, and added in a disgusted tone:

"This whole analytic attempt to destroy neurosis reminds me of David's fight with Goliath—analysis being the little David, neurosis the giant Goliath."

"Observe how masochistic you are in your objection," I remarked. "According to tradition, David killed Goliath. Why didn't you select a simile where the giant is in the end victorious?"

The example is paradigmatic for the confusionist's "arguments."*

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*It is obvious that the 12 specific subdivisions, intended as a small sample, need specific elaboration. The member of group 2, e. g., "promotor of his own pet ideas," is bent on silly single-mindedness, not because of "stupidity," only because the pet idea corresponds to the specific inner defense before the tribunal of inner conscience. In group 8, "specialists in simplification" put their supercilious negation of unconscious mechanisms in operation quite independently of their knowledge and IQ's; they are mortally afraid of their own unconscious. And in group 9, the exhibiters of "pseudo-imbecility" hold on to their "stupidity" because the "intake" of knowledge is refused, as there is identification of knowledge and the lactitional precursor, best expressed in Goethe's *Faust*, "to suck on wisdom's breast." Thus a pseudo-aggressive, though at bottom deeply masochistic, "revenge" is taken on the enshrined image of the mother. And so forth.

A DYNAMIC APPROACH TO THE TAT

BY NED CHAPIN

Introduction

When, in clinical work, a determination of the psychodynamics of a particular subject's behavior—the how and why of responses both covert and overt—is attempted, one seeks as inclusive a technique as possible. The writer has found projective techniques to be the most revealing of personality for clinical time and labor invested, and the TAT to be superior to other instruments in spite of its many shortcomings.

A worker's skill and approach to the field of personality, as J. B. Rotter[1] has pointed out, largely determine the usefulness and validity of the TAT. The reader will have to judge the writer's skill from the content of this paper, but the writer's approach, which has been termed intuitive with a stress upon causal sequences, warrants explanation. His principal ideological sources have included Alexander, French, Henry, Masserman, and Tomkins.

This paper will first seek to structure among some elements of TAT theory, then among some elements of more general psychological theory, and follow this by a discussion of the relationship between those two. The examination of a specific case will be used to illustrate the points made.

Theory of the TAT

Scoring

TAT scoring that is a corollary of the "specific content" school of thought yields too scanty data, in the opinion of the writer, for adequate interpretation if used alone. However, if used alone, TAT scoring that is a corollary of the "implied content" school of thought yields data with too little interprotocol comparability for adequate interpretation. To obtain copious data with good interprotocol comparability, the writer has drawn eclectically from these major schools of thought to obtain scoring categories that would prove revealing for his own manner and goals of interpretation.

Under the self-written method of protocol collection, psychological distance is greatest, with the result that variation in formal aspects of the protocol is both at a maximum and more purely

within the control of the subject than is characteristic with other means of administration. For example, the parts of speech, as aggregated and organized in the protocol, are a rather pure function of the subject's personality.

Interpretation

The interpretation derived from a protocol is a function of the analysis yielded by the choice of scoring categories, and is a function of the skill and theoretical inclination of the worker. To workers using an intuitive approach in interpretation, projection is both a most powerful tool and a most frequent source of error.

Administration

In taking the TAT, the subject builds from ambiguous situations, having for an externally imposed frame of reference only the specific unambiguous content of the instructions given, the specific content of the pictures, and the manner of collecting the protocol. The subject may violate instructions or distort content; the test administrator may vary the manner of collection at his own discretion.

To the test administrator, many ways of protocol collection are available, especially when working with subjects of above average intelligence where self-written protocols are practicable. Collection of an orally-given protocol at full speech speed, as by stenographer or recording machine, yields a smaller time-sampling of the subject's behavior than either of the two following methods, and shows more clearly the finer variations in response pattern at the expense of the larger more generalized ones. Collection of an orally-given protocol at less than full speech speed, as by examiner-written protocol, gives a longer time-sampling of the subject's behavior, and tends to subdue the finer response pattern variations, but magnifies the influence of the examiner as a stimulus in the testing situation. In contrast, collection of a protocol by self-written means minimizes the influence of the examiner, gives the longest time-sampling of the subject's behavior, lengthens the psychological distance between the protocol and the immediate test situation, and strongly subdues fine variations in response patterns in favor of the more generalized ones.

When collected from the subject immediately after protocol completion, some items of information greatly facilitate interpretation,

especially such data as: sex, age, weight, height, marital status, siblings, parents, mood during testing, and card preference.

Projection

In the TAT, the subject describes the world and himself as he both consciously and unconsciously considers them to be. Let objective reality be unknowable; each human being is aware of a cumulative reality to which he responds both consciously and unconsciously—that is, part of the reality he knows is but the repercussions of his learned responses, whether conscious or unconscious.

The TAT protocol, therefore, is a blending of memory products and self-fabricated creations. The selective function of the ego, operating in the testing situation with material previously selected by the same process in other situations (the reason the material stuck in the subject's memory) makes the memory-product faction highly reliable in interpretation. Equally reliable in interpretation, is the other faction, for it is a function only of the subject's mental processes. Interpretation, however, rarely can assess the apportionment in (and of) the protocol among these factions; rather, interpretation yields data on the use of psychological mechanisms such as distortion, confusion, condensation, projection, displacement, and symbolism. Such mechanisms possess interpretative reliability, because memory products and self-fabricated creations serve the subject as verbal or non-verbal realizations or formulations of his reality.

For the same reasons, everything in the protocol has significance; nothing is worthless. From the point of view of theory, given the same cards and a constant testing situation, the subject's personality is the only variable; and, hence, interprotocol variation is a function of the subjects' personalities. Since, without an assumption of intra-individual temporal consistency of component personality factions personality "testing" or "inventory taking" becomes meaningless, there exists (at least by assumption) a relation between mental products, and overt and covert behavior. When the mental products are taken in verbal form, since verbalization is the attempt man makes to express in communication symbols his conception of environment and self, the verbally-expressed mental products correlate directly and closely with behavior.

From a more clinical point of view, the subject incorporates into the protocol at his volitional option, material within verbal grasp. Material not verbally formulated is included as a function of the relative weakness and incompleteness of repression, as a function of the absolute magnitude of the cathexis of the material, and as a function of the TAT cards and the order of their use. Material verbally formulated is included as a function of both the control system in force, and of the need and emotion balance elicited during the testing situation. In short, from either the clinical or theoretical point of view, no story, and no aspect of any TAT story or lack thereof is insignificant.

Psychological Theory

Introduction

Four characteristics basic for psychological development that a child possesses at birth are intelligence, generalized consciousness, physiological needs, and an absence of adaptive behavior patterns. The course of psychological maturation of a child consists of the differentiation of the ego (reality testing), the acquisition of behavior patterns (learning), and the partial elaboration of physiological into psychological needs (needs and controls). These processes are functions of the intensity, amount, and types of physiological needs experienced, the quality of intelligence, the quality of physical equipment, and the nature and intensity of environmental press. Personality, the result of progressive cumulative interaction of these factors, is manifest as overt and covert behavior responses which function to reconcile internal demands with the press of external environment.

Ego

The process of ego differentiation is signally modified by the factors of receptor acuity, intelligence, the strength of physiological need, and prior learning. Ego differentiation itself is the qualitative discrimination of "thingness"—discrimination of one stimulus from another—and especially the qualitative discrimination among consciousness itself, the physical body, the "need-condition" of the body (emotion), and all other stimuli. The quality and extent of this discrimination is RT (reality testing). Receptor-acuity and intelligence both channel and shape the process of ego differentiation, because any impairment means either inadequate

mentally received data to work with, or inability to work adequately with the data received. Among the data received is the strength of the physiological need that is experienced—which is a function of the degree of inherent physiological need under the particular environmental press. This leaves the matter of prior learning, or association formation, for consideration.

Although learning takes place on two levels, the verbal and the non-verbal or manipulative, the learning in either case is either contextual or "sans-contextual." If the learning be contextual, the subject relates what is learned at one time to material learned at some prior time. This relating process can be intellectual or associational in nature. That is, either induction and deduction, or happenstance occurrence—usually of emotions or of random thought-sequences—may characterize the relating process. If the relating process pragmatically yield adequately-adaptive behavior patterns, then the learning is contextual. But learning is "sans-contextual" if the patterns yielded be not adequately adaptive.

The distinction between contextual and sans-contextual learning assumes importance in the process because the child starts out in life almost a *tabula rasa*. From that beginning, the process of maturation is cumulative, building upon previous learning. And, since the earliest learning that a child does is both the foundation for further learning and usually sans-contextual, a behavior tendency or mode of thought once started is usually both self-propagating and communicationally inaccessible.

Id

Contextual and sans-contextual learning temper the development and degree of need-recognition. At first, physiological needs are experienced as a generalized emotion. This generalized emotion is resolved, during the process of ego differentiation, into separate emotions. Many of these separate emotions become recognized, through learning, upon their recurrence as needs. The recognized needs of hunger and fatigue are usually examples of this comparatively direct process. The process often does not stop there, for through further learning, especially through generalization from associations, psychological needs are created. The recognized needs for achievement, and for routine work are usually examples of this process.

These processes are carried forward through the medium of learning. If that learning be contextual, then the resulting recog-

nized needs are adequately adaptive—that is, currently capable of socially orientated satisfaction. If that learning be sans-contextual, then either no recognized needs are developed, or the recognized needs are not adequately adaptive—that is, not capable of current satisfaction or not capable of socially-orientated satisfaction.

In other words, the processes of emotion-identification and need-recognition are functions of experienced physiological need-strength, and a "labeling" process. The "labeling" process is a function of the RT and intelligence of the child, and of the accuracy and consistency of the identification expressed by others of the child's expressions of his physiological needs. Some experienced physiological needs are in and by our culture usually so thoroughly, consistently, and accurately identified, as for example, the physiological need for food, that identification of the emotion is short-circuited by the seemingly direct recognition by the child of the emotion as a need, hunger (usually via contextual learnings). In other cases, most importantly sex, the physiological need experienced is often not identified as an emotion; and frequently the emotion is not recognized as sexual need (usually via sans-contextual learning). In general, the less accurate, less thorough, and less consistent the environmentally-obtained identification and recognition, the more devious and less socially-orientated are the expressions in behavior of the physiological needs experienced.

Under this concept, the conventional id would be the variable sum of unrecallable retained verbal learning, retained non-verbal learning, and the identified and non-identified emotions of the individual. By the same token, the conventional ego would be the variable sum of recallable verbal learning, recognized needs, and the awareness of consciousness (RT). These are variable sums, for the content of each is a function of learned responses to temporally variable environmental press and to the strengths of experienced physiological need.

Super-ego

As the process of ego differentiation proceeds, as emotions become identified, and as needs become recognized, an awareness develops of the need-satisfying attributes of some responses. The retention of these responses to needs and emotions is accompanied by generalization from the conditions characterizing the satisfac-

tion-yielding responses. This generalization is integrated and developed into a system of control by learning. Much of this generalization leads to, and is retained as, internalization of parentally exercized controls and as identification with parental figures who, by their examples, show how need-satisfaction is achieved.

Under this concept, the conventional super-ego is the variable sum of the Generalization of the Identification Process (GIP) and RT. This is a variable sum in that its content is a function of learned responses to temporally variable environmental press and to experienced physiological need strengths.

Personality

To describe a person in terms of RT, GIP, intelligence, etc., alone is meaningless. The factors that comprise personality are bound together and integrated through the medium of psychodynamics, for psychodynamics is the working relationship among the causal and associational sequences peculiar to a particular individual's behavior, overt and covert. Causal and associational sequences are formed through the learning process, and since the order among the contents of the sequences is independent of any *a priori* process, the psychodynamics of each individual differ from that of all other individuals.

Since the degree of specificity or generality of the elements of psychodynamic sequences varies from individual to individual, determining the degree of generality in conjunction with the degree of sequence interconsistency, quantifies personality integration. In other words, given the RT, personality integration is a function of the overdetermination of both responses and psychological mechanisms.

Readers with high space factors (in the Thurstonian sense) will derive considerable insight into personality by constructing in three or more dimensions co-ordinate systems, placing upon the axes such variables as RT, GIP, the consistency of apparent environmental causal sequences that are observed, the durability of parental love, the completeness of physiological need satisfaction by parents, intelligence, etc.

Relationship Between TAT and Psychological Theory

Introduction

In the interpretation of a TAT protocol, the magnitude of the consequences of any deviation from the prescribed conditions of

administration must be estimated. Lack of rapport, the most common and important of these deviations, changes the protocol form and content—usually toward scantiness of the stories, symbolism, and deliberate violations of common logic. In general, when rapport is known to be high (the test administrator is usually able to assess the degree of rapport), interpretation often can proceed directly from material stated in the protocol, but when rapport is known to be low, the representativeness of everything stated in the protocol is questionable. The degree of rapport also changes the emotional tone of the protocol through its impact upon the subject's current satisfaction state and balance among needs and emotions.

Intelligence

Many verbal aspects of intelligence are clearly revealed in the TAT protocol. Assessing the level of verbal intelligence is the first step in protocol content interpretation. The second step is to adjust in the mind of the interpreter the protocol contents for the obtained level of verbal intelligence. Non-verbal aspects of intelligence also show up to some degree in the protocol, but interpretation to obtain a reliable estimate is much more difficult than for the verbal aspects.

For the various means of estimating verbal and non-verbal intelligence from TAT protocols advanced by other workers in the field,[2-5] this writer has only respect. Their methods appear to be quite adequate, and are used by the writer in content interpretation.

Reality Testing

Since the TAT protocol is a projective document—an expression in verbal terms of the world as experienced by the subject—comparison can be made, after adjusting for verbal intelligence, between the "real world" and the one known to the subject. The degree of this correspondence is a measure of RT. Since the degree of correspondence that can be detected is a function also of the objectivity and knowledge of the TAT interpreter, care must be taken to assess both the skill of the interpreter and the general nature of the past environment of the subject. For defects in the former, training and experience can compensate; for ignorance of the latter, soliciting general information on the subject's past can compensate.

The various techniques for estimating RT advanced by other workers[2-10] in the field of projective techniques appear generally sound to the writer, and are used by him in content interpretation.

Emotions and Needs

The extensive work done by other workers on the identification from the protocol of emotions and needs, and on the degree of need satisfaction enjoyed, appears to the writer competent and fairly complete.[1, 2, 4-15] The confidence placed by some quarters in the representativeness of the material directly stated in the protocol appears to the writer not always well founded for he has seen in cases of low rapport, deliberate and successful attempt to introduce, by direct statement, nonrepresentative material.

Control Systems

The subject's conception of the testing situation will cause a large variation in the apparent control system as interpreted from the protocol. Little reliable check of the direction and magnitude of this variation can usually be made, because of the extent to which the control system usually lies within the verbal grasp of the subject.

The methods now current in the field for appraising control systems from the TAT as advanced by other workers,[2-6, 8, 9] are by the writer considered quite useful in content interpretation with little but nomenclatural modification. GIP can be obtained from them by a process of subtraction.

Psychodynamics

To understand the particular personality, the unique combination of the particular intelligence, RT, GIP, needs, and emotions, must be known. This combination element is best traced by a determination of the particular sequences that are characteristic of the subject in question—that is, by the application of psychodynamics. This tracing operation is similar to Tomkins' level analysis,[5] although utilizing specific behavioral threads.[16-18] The conditions of use and non-use, for example, of the various psychological mechanisms create a problem in psychodynamics.

These psychodynamic sequences, these behavior combinations, can by analysis be broken down into the elements of intelligence, RT, GIP, emotions, needs and the past environment of the subject. Some cases are simple, some appear extremely difficult, but

all yield to some extent to sound well-directed clinical judgment and intuition. Symbolism in the protocol is always a valuable aid in interpretation, but can be used only with a confidence which is a function of the interpreter's training, skill, and experience.

Case Example

Background

On a rainy Tuesday in mid-winter while dismounting from a trolley bus, the subject of this protocol fell to the pavement, apparently unconscious. She later reported that she had suddenly felt her left leg give way. The examining physician reported only a minor abrasion on the right knee, apparently a result of the fall. Because this physiological finding did not substantiate her complaints, the subject was referred for psychological examination. Only the TAT and questionnaire were administered.

TAT Protocol

The TAT was administered in the mid-morning of Thursday; the degree of rapport during administration was rated "good." The self-written TAT protocol follows, and, following it, are the scoring and a statement of the scoring categories.

Card 1. The boy in this picture has just received a violin. He had begged and pleaded with his parents until they finally agreed to pay one-half the cost, provided that he would pay for the other half. It had been hard for him to earn the money because his parents were rich and noone could see why he wanted money. He could have told his prospective employers why but his parents, determined to make it difficult, had sworn him to secrecy. But, at last the violin was paid for. As he beheld his coveted treasure his mind was filled with the wonderful days ahead. He saw himself on the concert stage, and after many recalls the people still clapping. He pictured himself as one of the world's greatest violinists, but little did he know. The great giver of life decided it was time for him to come home, and our poor friend is no longer in this world.

Card 2. The gaze of the woman is not just a mere look at some living object, it is a look into the future. She is faced with an important decision. Her main desire had always been to be a school teacher; she had lived and breathed just for this vocation. But she had been told that if she wanted to be a good teacher she must

go away to better schools. Of course she wanted to go away but because of the lack of money she had to stay.

This young girl settled down with the young man similar to the one in the middle ground, and they raised a family. Now the "young girl" has a daughter who is at the same age the mother was when the mother had to give up her life ambition. This daughter wants to leave, and the only way she can leave is by having the mother give her all the money she has saved. The mother confident that her son, in the field, will take care of her has given the money to her daughter who is now looking into her future.

The mother as she leans against the tree sees her daughter making a big success in school. The mother is right for this young girl is to be a Phi Beta Kapa, and world famous.

Card 4. The man in this picture has just been caught by surprise by his dead wife. He had killed his wife to be with this girl and his wife had sworn revenge. Because he is the only one who can see and hear his wife he finally is driven to insanity. The girl in this picture after finding out what was wrong with him commits suicide.

Card 7GF. The woman in this picture is trying to comfort the young girl whose mother just died. This woman has been like a mother to the girl. The mother had hated her daughter and in turn the daughter had hated the mother. The young girl has been listening to the older woman reading the bible and is beginning to understand that love conquors all. After the woman stopped reading, the girl understood why her mother acted as she did, and she felt a strange glow of love for the dead woman.

In the years to come this understanding helped her to be one of the best juvenile counselors in the world.

Card 3GF. The girl in this picture has just seen her brother die a most horrible death. Years ago her brother was supposed to go on a trip with a relative but she hadn't told him until it was too late; she went instead. Her brother, when he found out, had developed some poisonous drink and had put it at her plate; when she came to the table she told him that she had won a free trip to some place far away and she was giving it to him. Her brother realizing what a horrible thing he had done had drunk the poison instead.

She went on the trip and became a great singer for in her agony she had developed a throat condition that gave her voice a beauti-

ful quality. She spent all her money for good works and died penniless.

Card 6GF. The girl in this picture has been trapped by her husbands killer. She had followed all the clues he had accidently left and had followed him to his apartment. He found her trying to spy on him and brought her in this room. As he bent over the couch she took out a gun gun and shot him.

When the police came they didn't believe her story, and she was convicted of murder in the first degree.

Card 8GF. The woman in this picture is posing for a poor artist. When he completes this picture, it will make him famous, but neither of them know this.

The artist had seen this woman cleaning the hall stairs one day, and struck by her expression had asked her to pose.

When he completed the picture and asked her name he found out that she was a famous novelist who was writing a novel about her present surroundings. She had never allowed anyone to take a photo of her, but taking pity on this poor man she had allowed him to persuade her to pose.

When the picture was exhibited it made him a famous man.

Card 16. This is a picture of a bird dog pointing at a bush. The master of the dog hurries up to see what the dog has found and finds a dead body of a woman, his wife.

They had had a quarrel before he left to go hunting, and she had threatened to kill herself if he left. Because he decided she needed a lesson in self-control he had left. She had beaten him to his favorite hunting place and was going to hide and kill him, but in her hurry she had tripped and the gun had gone off, killing her.

He is found there by the police and he explains the story; the police do not belive him and he is hung.

Card 13MF. The woman in this picture has just died. The man had tried, in desperation a new drug and it killed her. He then tries it on himself with wonderful results, and becomes famous.

Card 9GF. The woman in the tree is spying on her husband's girlfriend. She has suspected her sister for a long time and now she knows. She follows them, and talks to them, and after much discussion decides they are in love and agrees to a divorce.

She remarries later on and raises a large family and is very happy.

Card 14. The man in the picture is in his bedroom; he was suffering from insomnia and finally decided to get up and get some fresh air. After looking out the window, he becomes sleepy and goes back to bed with pleasant dreams.

Card 18GF. The girl in this scene is playing a dramatic role. She has studied for a long time and this is her big moment. The audience likes her and she becomes a star.

Card 11. The people in this picture are running away from the animal that is chasing them. There was an earthquake, and it woke this animal up. The animal thinking the people disturbed it, starts to chase them, but they make an escape by flying away in their airplane.

Questionnaire

The questionnaire was administered just after the TAT in the late morning of Thursday. Since omissions on this questionnaire are rare, the four in this case are therefore probably significant.

(Sex, height, weight?) female, 5-5, 125; (Date of birth?) OMITTED; (Marital status?) single; (Occupation?) student—work at Sears; (Amount of sickness?) none; (Education?) OMITTED; (Mood during protocol creation?) tired; (Father's occupation?) maintenance foreman; (Mother's occupation?) housewife; (Older siblings?) two; (Younger siblings?) none; (Characterization of past environment?) OMITTED; (Favorite hobbies?) dancing; (Card liked best?) No. 1; (Card disliked most?) OMITTED.

The date of birth was August 12, 1931; the subject is a college freshman; the two older siblings are brothers.

Scoring

An examination of the scoring categories shows that eight (No.'s 2, 3, 4, 5, 9, 13, 14, and 15) require psychological knowledge to score, although they need not be personally scored by the interpreter himself, but that the other 11 can be computed from the protocol by anyone possessed of the equivalent of a high school education.

Explanation of Scoring Categories

Category 1: Index of story length.

Category 2: Time approach where N—normal (P, C, F), P—past time, C—current time, F—future time; preceding superscript if any—introduction type; subscripts if any—story characterization (a—anxiety).

Category 3: Concept type (symbols and interpretation from the Rorschach).

Category 4: Introduced figures and objects.
Category 5: Omitted or distorted figures and objects. The plus and minus signs reflect the quality of picture integration in the written and implied story.
Category 6: Index of P time verbs used and index of verbs used for P time.
Category 7: Index of C time verbs used and index of verbs used for C time.
Category 8: Index of F time verbs used and index of verbs used for F time.
Category 9: Intelligence estimate in IQ units.
Category 10: Index of frequency of complex sentences.
Category 11: Index of word length.
Category 12: Index of sentence length.
Category 13: Estimate of reality testing (Q—"queer" content or thema).
Category 14: Direction and degree of major subjective time stress (scale 0-10).
Category 15: Picture (No. 0) to concept (No. 10) dominated stories.
Category 16: Index of the ratio of passive to active verbs.
Category 17: Index of the ratio of adjectives to active verbs.
Category 18: Index of the ratio of nouns to verbs.
Category 19: The "40 Index." The sum of the index of the ratio of nouns to verbs, plus that same index, times the algebraic difference between the preceding tabular difference of the index of P time verbs used, and one-half the succeeding tabular difference of the same index; over 1.0 plus a constant times the algebraic difference between the preceding tabular difference of the index of total verbs used, and one-half the succeeding tabular difference of the same index.

Note: WPM—words per minute. The scorers' comments are included here also.

Interpretation of Scoring

For clarity and simplicity, the writer will first go through a step-by-step interpretation of the protocol scoring, using the questionnaire as a frame of reference, and will then summarize the findings—*without any reference to the verbatim protocol itself. For this method of interpretation, it is not even necessary to see it.*

Interpretation by Scoring Categories

Category 1 shows a greater decline and a greater fluctuation in story length than is normally expected. The inference is either emotional lability, fatigue, insight into the test mechanism (self-awareness), an inadequate control system, or some combination.

Category 2 shows an unvaried time approach. This is highly unusual. The inference is either rigidity, aroused anxiety, attitudes of distrust or hostility, feelings of inferiority, insight into the test mechanism (self-awareness), or some combination. The footnote is significant, for heavy use of the present progressive tense is usually an indicator of pervasive conflict subjected to repression. The rather low writing rate of 13 WPM in this context suggests *strong* emotional blocking, which in the presence of a lack of card

TAT Scoring of Cited Protocol

Card No.	1	2	4	7GF	3GF	6GF	8GF	16	13MF	9GF	14	18GF	11
Scoring Category No.													
1	1.9	2.5	0.7	1.2	1.7	0.8	1.3	1.2	0.4	0.6	0.4	0.3	0.5
2*	^{c}N	^{c}N	^{c}N	^{c}N	^{c}N	^{c}N	$^{c\text{-}f}_{a}N$	^{c}N	^{c}N	^{c}N	^{c}N	^{c}N	^{c}N
3	W	W	W—	W	W	W—	W	W	W—	W	W	W	W
4	parents	none	wife	mother	brother	husband gun police	artist	man wife police	none	husband	none	audience	people
5**	∓	+	± picture	± doll	∓	±	+	∓	∓	±	+	∓ stairs	+ bridge
6	8-5	3-4	4-4	6-4	9-6	9-5	7-2	6-6	4-4	0-1	4-4	0-2	3-5
7	2-2	6-4	6-2	4-2	1-1	1-1	2-3	4-2	6-2	10-2	6-2	10-6	7-3
8	0-3	0-2	0-4	0-4	0-3	0-4	0-4	0-2	0-4	0-7	0-4	0-2	0-2
9	135	125	125	125	130	125	120	120	120	125	120	125	120
10	0.8	1.4	1.0	1.0	2.5	1.5	1.0	1.0	0	0.3	0	0	0.5
11	5.6	5.0	4.9	5.3	5.1	5.0	5.2	4.7	5.3	5.2	5.2	4.9	5.4
12	0.90	1.05	0.85	0.90	1.15	0.75	1.00	1.05	0.50	0.70	1.00	0.55	0.80
13**	Q	Q	Q	Q	Q	Q	Q	?	Q	—	—	—	Q
14	F8	F7	F5	C7	F5	F4	F5	F5	F7	F4	C5	F5	F3
15**	8	7	7	4	8	6	5	—	7	6	4	6	4
16	0.7	0.7	0.6	0.4	0.3	0.2	0.9	0.4	0.7	0.4	1.5	0.7	0.5
17	1.1	0.9	0.6	0.9	0.7	0.1	0.8	0.4	0.7	0.5	1.5	1.0	0
18	1.2	1.4	1.5	1.8	1.2	1.1	1.3	0.8	1.0	0.8	1.6	1.4	1.5
19	1.9	0.6	1.5	2.0	1.6	1.0	1.7	0.8	1.4	0.2	4.4	0.5	2.2

Notes: WPM—13. *Category 2; dominant use of "is ——ing forms in introduction. **Categories 5, 13, 15: difficult to score because of use of symbolism.

rejections suggests a high achievement need. These factors in turn suggest that the invariant approach is a manifestation of attempted self-control. The suggestion from the questionnaire of a lack of freedom adds weight to this interpretation.

Category 3 shows an unvaried intellectual approach. This is highly unusual. The inference is either extreme constriction, aroused anxiety, high achievement need, rigidity, defective self-control, inferiority feelings, low spontaneity, a background of personal unhappiness, overt activity preference, or some combination. The subject's refusal to name the card disliked most is evidence in the same directions. (The usual Rorschach interpretations of W are also applicable here.)

Category 4 is one for which as yet the writer has found no adequate inclusive interpretation.

Category 5 is similar in status to 4, although the plus and minus scorings are *roughly* equivalent to Rorschach F scorings. The note suggests an interpretation of over-cathexis, and defective, unstable RT.

Categories 6, 7 and 8 are similar in status to 4, but yield considerable information when considered as a group. Emotional instability and low RT are clearly indicated in the pattern and spread. The weak verbal time-stress of current time affirms the interpretation of an unhappy background, and suggests that the routine of day-to-day living is fraught with problems, a further indicator of both a tendency to over-cathect and of generalized emotional lability. This in turn suggests that category 4 is probably very important in content interpretation.

Category 9 shows no unusual characteristics, but suggests that intellectual application is a consistently used technique.

Category 10 shows both a marked decline and a wide fluctuation. The inference is that the social validity of the results of intellectual application is subject to impairment because of low RT, for sensitivity to interrelationships and to the finer shades of the structure of external reality apparently requires volitional maintenance.

Category 11 shows an unusual pattern of variation about a not unusual level. The inference is that the carry-over of education into day-to-day life is rather low. The suggestion is either of emotional lability, conflict, an unusual home environment, or some combination.

Category 12 shows uncommon trends about a common mean which affirms the carry-over inference, and suggests anxiety, perhaps to the point of blocking, affirming a previous inference.

Category 13 is normally scored as a percentage of the intelligence estimate to indicate a gross level for RT. The pervasive symbolism and queer content rendered such a scoring impossible here. The clear inferences are rigidity, over-cathexis, and patternedly-defective RT; and the suggested inference is either repression, emotional lability, a background of extensive persistent thwarting, or some combination.

Category 14 indicates a basically strong future orientation in outlook. A comparison of this category with 7 and 8 re-affirms the tendency to over-cathect, but in addition suggests that over-cathexis is used involuntarily as a "public" adjustive technique.

Category 15, because of the rigidity of approach observed with this subject, yields, to the writer's current knowledge, no significant interpretation on an inclusive basis.

Category 16 only once rises above 1.0. This indicates a very active person, one given to physical and overt expression (note the "dancing" and "tired" responses on the questionnaire). The inference is either that inferiority feelings are physiologically directed, that physical restriction is the equivalent of thwarting, that the subject has better than average self-awareness, that an inability to define the body adequately in ego differentiation is associated with the tendency to over-cathect, that the subject is impulsive, that the subject is egotistical, or that some combination is descriptive.

Category 17 strongly affirms the inferences of impulsiveness and overt expression tendencies by its generally low level and its relation to the No. 13 scores. Experienced emotion is given relatively free expression, but fair control is maintained to the extent of the conscious attention given to the matter. This further suggests that the symbolism, the over-cathexis, is a "leak-expression" of curbed physical expression. This, in turn, suggests an anxiety-characterized RT, associated with honest identification of emotion in a physiological setting of easy arousal of over-strong emotion. In turn, this points to a distorted self-awareness.

Category 18 is similar in status to 4, but appears superficially related to experienced anxiety.

Category 19 is the "40 index," an index of the openness, the lack of desire to, or inability to distort story content when in its higher

values. When in its lower values, it is an index of the thoroughness of applied defenses to anxiety-arousing material. As such, it is a valuable guide to content analysis of TAT stories. On an inclusive basis, it is an indicator of the degree of straightforward normal adjustment to the external environment. Given the other scores of this subject, the low 40 index suggests that rapport can never be excellent, that the environment is seen as hostile, and that the adjustive technique preferences tend to structure the environment un-normally (this does not necessarily, however, indicate a heavy use of projection).

Interpretation by Card

Card 1. Shallow intellectualization, curbed overt activity, strong future time stress are the basic means of handling a new situation; but this leaves the accuracy and completeness of environmental perception considerably lowered, because of the rise of over-cathexis expressed as symbolism. The suggested inferences are blocking, inferiority feelings, high achievement need, a tendency to flight, increased insecurity, and repression.

Card 2. The story content is disguised, and since the latent card content is one of response to the environment, the scores are significant. The improved RT, greater current time stress, and improved "depth" of intellectual application, imbedded in scores indicating aroused anxiety, suggest a strong achievement need.

Card 4. The latent card content is sexual, and the response disrupts thought-process integration. The subject, though an active person, shies away from having to deal definitively with the stimuli, suggesting that flight rather than fight is the basic adjustive technique. The suggested inferences are of inferiority feelings, physiologically directed, and of difficulty in self-control.

Card 7GF. Anxiety is the response to the latent card content of attitude toward the mother figure. The rather shallow intellectualizing accompanying the anxiety suggests in the light of the fairly high 40 index the absence of any successful way of coping with the anxiety aroused by the mother. The unusual 14 score suggests that the subject finds herself forced to fight rather than flee, which, in turn, suggests that the mother figure must be thought to be very powerful.

Card 3GF. Since reasons for guilt or unhappiness are the usual latent card content, the long story and hard retreat into the past

tense indicate the story content to be revealing, although the 40 index indicates interpretation may be difficult. Since unhappiness is usually associated with decreased motility, the fall in the 16 score points to guilt. Aroused guilt, the scores indicate, is met with improved intellectual performance but with no improvement in RT, perhaps even a fall. The introduction of a brother figure in a guilt story seems significant.

Card 6GF. Since the other impairments of integrative capacity are found on the "sexual" cards, the indication is that the response to the father figure is associated with a sexual response. The scores indicate that the aroused feelings toward the father are restrained at the expense of intellectual integration although without noticeable impairment of RT. This, with the full retreat into the past tense, and the balanced future content in the story, suggest repression as the adjustive technique used. The introduced gun and police suggest thwarting, and the low 17 score suggests an open expression of feelings only in private situations.

Card 8GF. To a latent content of aspiration and social role or of current preoccupation, the response is undisguised anxiety, future time stress, *relative* inactivity and passiveness, and daydreams (scores 5, 9 and 19). Apparently therefore, when not in interpersonal contact situations, the subject may admit the presence of anxiety, but seeks relief and expression through daydreams of the "future."

Card 16. The scores indicate that the real story content is disguised, but very representative. This subject is apparently active and dominant in interpersonal relations.

Card 13MF. The serious impairment of integrative capacities by the sexual latent card content, the retreat from present time, and stress upon the future all indicate arousal of severe anxiety, perhaps even blocking. Sexual emotion is apparently very disrupting.

Card 9GF. To a latent content of attitude toward like-sexed peers or to women in general, the response is strong anxiety and immediate action. The use of only the present tense testifies to the intensity of the response aroused; the peculiar, for this subject, time stress and weak intellectual application indicate a hurried "stop-gap" approach, and the introduced "husband" points toward a rivalry situation. The very low 40 index suggests a sym-

bolic interpretation may be necessary, for, as an aspect of the response, the subject apparently really "covers her tracks."

Card 14. A latent content similar to that of Card 8GF elicits a very different response. This further re-affirms a tendency to over-cathect. The 5 and 9 scores suggest, in the configuration of the other scores, an introspective, self-preoccupied response to the card. The split time stress, with the out-of-balance present, in the presence of the high 18 score and low 15 score, points to aroused anxiety; but the, for this subject, passive response (scores 16 and 17), together with the missing 10 score and sharp, strong increase in the 12 score, points to a relaxed self-response in apparent "out of phaseness" to the anxiety indicated. The high 40 index indicates something unusual, present quite openly, in the story.

Card 18GF. The sharp impairment of intellectual functioning to a latent card content of aggression and the failure to use other than the present tense indicate a high resistance to expressing aggressive impulses, a conclusion affirmed by the, for this subject, rather high 16 and 17 scores. The low 40 index in this context suggests repression.

Card 11. A rather ineffectual intellectual application and uncommon use of verbs, the fairly high 40 index and low 15 score suggest psychological distance with this picture. On the basis of this and of the scoring of the previous cards, the latent content of "instinctual drives" probably has been responded to.

Summary of Interpretation of Scoring

Intelligence

The subject's basic verbal intelligence level is the equivalent of an IQ of 125 with the nonverbal intelligence level probably not superior to the verbal. Aside from a normally maintained mediocre integrative sweep, the subject's routine intelligence functioning is rather ineffectual, and does not utilize her full capacity. When experiencing guilt or confronted by a recognized necessity for intellectual performance, the subject noticeably increases the depth of her intellectual application, this being especially true of her grasp of relationships and capacity for generalization. The subject eases the experienced anxiety with shallow intellectualization. Over and above these influences, is the severe emotional blocking of her intellectual functioning associated with any emotion aroused.

The subject is so taken up by the emotional aspects of existence that intellectual functions take a subservient role. The influence on her, therefore, of academic education is slight.

Reality Testing

From the scoring, the subject's basic reality concept, her basic awareness, is unrevealed, aside from the fact that the data about the body are somehow important. Her self-concept includes feelings of inferiority, physiologically directed; lack of confidence in her performance abilities; awareness of apparently easily aroused emotion; and aversion to inactivity. She has a distorted self-awareness.

The accuracy and extensiveness of her awareness of external reality is impaired and rendered unstable by the quality of her intellectual functioning, and by an intimate association of an attributed symbolic meaning to the events and objects she observed. In addition to this distortedly selective sensibility, she apparently projects her aggressive tendencies.

Emotions and Needs

Emotional lability is the predominant aspect of the subject's subjective experiences. Anxiety is both pervasive and associated with most emotions, and emotional meanings are attached to common events and objects. The subject has a strong achievement need, but apparently need is usually not recognized and emotion is usually not identified. The mechanisms and reasons for this failure are not evident from the scoring, although the presence of blocking strongly suggests repression.

GIP

The attempted rigidity of the control system in the presence of sexual involvement with the father, and anxiety and aggression toward the mother, evidences a defective GIP. The over-cathexis (symbolism) and impaired intellectual functioning make it very difficult to attain socially valid satisfaction-condition generalizations for control—as a substitute for GIP through parental identification. This heightens her activity preference.

Psychodynamics

Flight (for which the scoring offers no etiology) is the subject's basic adjustive technique, and she abandons it only under severe

immediate environmental press and under aroused anxiety and aggression. Toward her mother, her response is aroused anxiety and aggressiveness. Toward her father, her response is aroused sexual feeling. Toward her brothers, her response is aroused guilt. To all aroused emotion, her response is anxiety. To her emotional lability in general, her response is repression and (physical) activity. This easily-aroused emotional lability, including the anxiety, which leads to the blocking that is observed, probably is the cause for the manifest pressure for, and attention to, self-control in interpersonal contact. Publicly, the subject restrains her dominance and activity at the expense of increased over-cathexis and increased stress on future time. In familiar interpersonal contexts, she is overtly expressive and active, but probably still retains some of her rigid attempts at self-control, for her past has been unhappy. By herself, the subject is probably engrossed in anxiety-ridden fantasy.

The presence of severe thwarting of needs has led to over-cathexis in the form of symbolism. Physical restriction including that of emotional expression, is, to her, thwarting, to which the subject responds with aggression and hence, also, with anxiety. This thwarting, she attempts to avoid, by being dominant and active in interpersonal contact, and, when by herself, attempts to compensate for by fantasy. Her anxiety which is augmented by threats to her security, as through rivalry or through arousal of her inferiority feelings, causes her to reject the present, and to cathect the future, because of an unhappy past.

Conclusion

Summary

Having for a frame of reference only a brief questionnaire, the writer, through interpretation of the *scoring* of a TAT protocol, has shown that psychologically revealing information can be obtained about a subject's personality *without ever actually seeing the verbatim protocol.* In fact, from the application of this limited approach alone, *more* psychologically revealing information has been obtained with greater certainty than some workers appear able to obtain, even when using nearly every current available trick of the trade.

What makes this approach as penetrating as it appears? In the first place, traditional theory was modified somewhat to allow

validity to be invested in slightly differing parameters of personality, which, given the nature of the TAT, allowed validity to be invested in heretofore relatively unutilized aspects of the TAT protocol. Inductive reasoning produced the specific scoring categories, and—teamed with the theory—provided intra- and inter-interpretations. To increase the probability of, and to clarify the dynamic content of, the interpretations derived, the advancing-frame-of-reference technique was applied through use of progressive interpretation against a background provided by a questionnaire. In the writer's opinion, this method, as applied here, constitutes a dynamic approach to the TAT.

Content Interpretation

Introduction

But the process need not stop here. The standard interpretative techniques advanced by other workers can now be applied to the protocol, again using progressive interpretation and the information already gained as the frame of reference. Since the techniques of other workers are well understood, only the full interpretation is given below to enable comparison with the interpretation obtained without the presence of the verbatim protocol. This interpretation, it should be stressed, has been drawn entirely from the questionnaire and the Thematic Apperception Test, for they were the only psychological instruments employed.

Intelligence

The subject's effective intelligence level is the equivalent of an IQ of 125. Frequent strong emotional blocking seriously impairs her intellectual functioning, and because the emotional aspects of existence claim so much of the subject's energy, intellectual functions take a subservient role.

The analytical trend of her routine intellectual functioning, in the presence of the mediocre integrative sweep that is usually maintained, has provided a good means-ends cognizance. However full utilization of intellectual capacity is rarely realized, for thought processes often lie beyond volitional control, to which the analytical trend of thought is a reaction-formation. When strongly experiencing guilt or achievement need, intellectual application, especially the grasp of relationships and capacity for generalization, deepens noticeably. The anxiety experience is eased with shallow intellectualization.

Reality Testing

Although her self-awareness is a mixture of self-consciousness and of strongly cathected, often distorted, self-concepts, the subject's basic awareness is of turbulent non-identified emotion, bounded by the limits of the physical body. External reality is selectively experienced as impinging forces upon the body.

Because of her pervasive over-cathexis of events and objects (use of symbolism) and externalization of impulses (use of projection), the subject suffers a distinct loss of distance with the content of her mental processes and impaired ability to recognize manifest external reality accurately. However, the subject pays fairly strict attention to the *quantitative* aspects of apperceived reality, partly as a compensation, and partly as an aid to repression.

Emotions and Needs

Emotions are inherently strongly experienced and easily aroused (but strongly repressed). Emotional meanings are attached to events and objects, and anxiety is pervasively predominant in subjective experience. Only the shallow and conventionally demanded emotions are identified and allowed open expression; but, even so, the subject robs them of sincere feeling.

Need-recognition is at a low level, and when present is accompanied by a lack of emotional insight.

GIP

Because of the character of her early environment, a normal GIP could not be developed; instead a combination of anxiety, aggression, flight, self-awareness, and repression served the role. The over-cathexis (symbolism) and impaired intellectual functioning largely precluded either extensive or refined satisfaction-condition generalizations from the social milieu. Because her ineffectual attempts at identification included conflicting masculine and feminine elements, the subject has attempted, as compensation, to incorporate conventional cultural behavior codes on a verbal level to supplement her control system.

Psychodynamics and Reconstructed History

During the oral phase of maturation, the subject had a very permissive environment, in which her needs, when she made them known, were adequately met. This allowed her, because of inherently strongly experienced emotion, to be impulsively and as-

sertively expressive. However, the necessity of having to make her needs known made her aware of her dependence, and of herself. In this context, the oral erotism of the period became associated with bodily stimuli because of a copious physical display of maternal affection.

Toilet training was instituted by the parents before the subject was capable of adequate physiological performance. Because of the physical thwarting of impulsive expression of her emotional response to the demands made upon her, she learned emotional repression, and learned to associate anxiety with the emotion experienced. The increased attention to the physical self, in the presence of thwarting, anxiety, and repression, channeled emotion into a cathexis of physical activities, increased her self-awareness, and laid the basis for physically-directed inferiority feelings. The thwarting aroused hostility toward the parents, and the sense of her helplessness at their hands reinforced her dependent feelings.

As the subject lost the charm of being a baby, her parents placed her on a position of equality with her brothers. She was neither shielded from them, nor given special consideration because of her sex; no attempt was made to direct her social development specifically, for she was just allowed "to grow like Topsy." Toward their children, the parents were firm, consistent, and unbending in attitude.

Sibling competition for parental favors quickly developed into a complex interplay of aggression and counter-aggression. Physical performance was often the basis for parental favors, and because of her brothers' superior maturation, the subject suffered strongly increased inferiority feelings. The pressure of thwarting from repeated failure channeled her cathexis of physical activity into a full-fledged, strong, achievement need, and channeled her impulsive emotional expression into a growing drive for active dominance. The presence of the increased anxiety further increased emotional repression.

The aggressive interplay among the siblings included the subject's "being framed" by her brothers so that she "got the rap" for their escapades. In addition, in relations with her peers, the subject was often the loser, and hence the one to suffer the consequences of her brothers' aggression and counter-aggression. These traumatic situations caused a generalization of anxiety to include its association with the emotions aroused in interpersonal rela-

tions. She compensated for this very severe thwarting by channeling her emotions into over-cathexis through the imputation of symbolism to specific events and objects encountered in the course of interpersonal relations; and by further increasing her active dominant trends—for she observed that by efforts at dominance, the environment could often be turned to her advantage. Since counter-aggression often failed or boomeranged, the resulting sense of helplessness both strengthened her dependent feelings, and her repression of them. Self-awareness also was increased by the results of the aggressive interplay, and this, her dependence, her emotional repression, and her anxiety were consolidated into a basic flight-withdrawal mechanism. Because of over-cathexis, dominance, and repressed aggression, this mechanism showed itself as social distance, insincerity, and impersonality in interpersonal relations; as a preference for an analytical trend of thought; as anxiety-laden fantasy; and as projection also of her hostility and fearful helplessness through ideas of spiritualism and predestination. By identification with the aggressor brothers, the subject developed a mildly masculine, weak GIP.

With the developing dim awareness of her sex, and under the pressure of her impulses, the subject developed a sexual interest in her brothers and father. The sibling trauma precluded expression of her sexual impulses toward her brothers, but because her father was comparatively responsive toward her, she formed a firm Oedipal attachment. However, the reaction of the mother strongly increased the subject's use of repression, and hence limited the expression of the Oedipal interest to symbolic forms. Heightened inferiority feelings, and some identification with the mother have been other consequences of the as-yet-unresolved Oedipal attachment.

Upon becoming aware of the non-feminine trend of her daughter's development and her apparent interest in the father, the subject's mother gradually proceeded to attempt to take the girl in hand, her technique being verbalization of her interpretation of the subject. The results of this shame technique were to arouse aggression toward the mother, and to add strong guilt feelings to the subject's personality. Guilt became associated with masculine or assertive modes of expression, and with any expression of impulses, which resulted in strengthened use of repression to the point of complete overt denial of emotion. The thwarting nature

of the guilt feelings markedly deepened her over-cathexis (use of symbolism) and withdrawal into fantasy besides partially redirecting her dominant tendency by the addition of a nurturant drive to her strong achievement need at the expense of overt admissions of the dependence she felt. The abasement demanded increased her inferiority feelings which, in the presence of increased thwarting, led the subject to adopt social codifications such as religion, arbitrarily, shallowly, and insincerely, as an aspect of her attempt at rigid control of her impulses. This guilt-thwarting increased and further distorted the subject's self-awareness; increased her projection of hostility and abasement; and increased—in conjunction with her basic flight-withdrawal mechanism—her cathexis of future time. Although it resulted in some identification with the mother, it increased her feelings of social distance.

The subject suffers pervasive conflict between repressed dependence, inferiority feelings, intense anxiety, and blocking on the one hand, and a need for achievement, dominance, and nurturant action on the other. Since she cannot play a feminine social role because of the hostility and repression of dependence that she feels, she turns for sexual satisfaction, because of her physiological orientation, both to masturbation and more sublimated forms of physical activity. Her basic adjustive technique of flight-withdrawal from her traumatic past and anxiety-ridden present, is by way of an insincere and arbitrary use of cultural trappings, which, because of the content and quality of her subjective experiences in the presence of repression, results also in fantasy, nightmares, and feelings of social distance.

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ODORS OR OZONE

BY GERSON DAVIDSON, M. D., AND JOHN H. TRAVIS, M. D.

Ward 14, a section of the main building of Manhattan (N. Y.) State Hospital, provides treatment for 100 aged men, 75 of whom require round-the-clock care in bed. They receive their feedings, baths, treatments, and all sanitary ministerings in one huge room 95 feet long, 42 feet wide, and 12 feet high.

Ward 14 projects into a courtyard embraced by the building wings which thus impede the fresh cross-currents of air so necessary in a setting of this specialized nature. The building itself bears on its cornerstone "1870," the year of its inception. Naturally, in those far-off days, convections, concentrations, circulations and conditionings of the atmosphere were imaginative figments for the future. In a room of such heroic proportions, built long ago, one would expect to find in corners and crannies, eddies and pockets stagnating with acrid air. One of the overruling objectives of all hospital administrators is to provide for their rooms and dormitories an unremitting supply of fresh air. In structures of ancient vintage, the achievement of such a goal is beset with many obstacles.

It so chanced in January 1951 that there was made available to Manhattan State Hospital a piece of equipment for purifying the air and energizing the circulation with additional supplies of ozone. The apparatus is so constructed as to enable contaminated air to be drawn by a fan over a grill where it is "reconditioned" by a "ray" process. The contrivance itself is suspended from the ceiling, and is about eight feet from the floor. Ozone is formed, and with its predominance in the surrounding air a more pleasant atmosphere is obtained. With this machine came provision for colorimetric testing. For two months this testing was carried out daily throughout every section of the ward, and a record was kept of the degree of ozone concentration.

Following the installation of the apparatus, a marked improvement in the atmospheric conditions in Ward 14 was found. Visitors noticed it, and doctors, supervisors, nurses, attendants, all were profuse in their volunteered statements about the amelioration of atmospheric conditions. Not only was the physical enhancement encouraging, but possibly of more importance still was the boost in the sense of psychological well-being. This improvement in

working conditions, of course, is a major factor in any management-employee relationship. When the mechanism was transferred for a trial to another section, the ward ensemble were most vociferous in their protests because of this migration.

The question of irritative incidents affecting the upper respiratory tract has arisen in connection with this creation of ozone. In the beginning two attendants spoke about throat congestions or headaches, but obviously this was due to the improper regulation of the machine fan. One patient lying directly under it had "sneezing attacks" for about two days. One investigator exposed himself to the machine on three different occasions, each of about 10 minutes duration. During the first two exposures there was some throat irritation, but on the third, no such reaction was experienced. None of the others had any complaints to offer, and everyone working on the wards—three shifts—was questioned. One of the staff doctors was a nose and throat specialist before entering service at the hospital, so upper respiratory affections are referred to him. He reports no bronchial, laryngeal or pharyngeal phenomena passed before his purview on ward 14.

The "air cleaner" was sent to ward Main 6 which has much the same characteristics as ward Main 14, and there further favorable reactions were observed.

Summary

The equipment under consideration was installed January 3, 1951. It is the best opponent of odors yet encountered. Every conceivable sanitary measure in the interests of sanitation had previously been tried including soap, water, rubbings and scrubbings. None approaches the satisfactory results effectuated by the mechanical set-up herein described. Incidentally, during the nearly two years of daily operation, no repairs have been necessary for any component part.

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THE PROBLEM OF ANXIETY IN GROUP PSYCHOTHERAPY ON A CHRONIC MENTAL HOSPITAL SERVICE

BY GERDA WILLNER, M. D.

PART I

Introduction

According to modern concepts, anxiety arises out of a faulty relationship between the individual and other persons in his environment. Neurotic as well as psychotic patients are subject to anxiety, which indicates the presence of a conflict.

Conflict has roots in childhood when a person is still weak, helpless, and utterly dependent upon the significant persons of his environment—such as his parents or his teachers—to gain satisfaction and security. He must submit to the powerful irrational pressures of his environment which he perceives as hostile. He, in turn, develops feelings of hostility which he has to suppress in order to continue to be accepted and loved. Thereupon a conflict between two opposing tendencies results; and the individual is torn between feelings of dependency and feelings of hostility! Thus the state of "basic anxiety" (Karen Horney) is set up.

This basic anxiety may accompany a person throughout his life; and he tries to alleviate it by various means of defense. The neurotic patient will use avoidance methods such as phobias, compulsive, obsessive and ruminating symptoms, fugues, and psychosomatic illnesses. The psychotic patient may develop delusions and hallucinations by projection and externalization of his conflict in an attempt to rid himself of anxiety and guilt-feelings. If the psychotic patient is still accessible and his psychosis has not progressed to such an extent that he withdraws from the showplace of reality, he will benefit greatly from individual or group psychotherapy.

Group psychotherapy is an ideal means to improve disturbed interpersonal relationships. The group represents, for its members, their own families. The therapist is perceived as the head of the family and the group members are the images of siblings. Sibling rivalry, competition for the love of the parents and traumatic childhood experiences are re-enacted, and the patients once more become helpless children at the mercy of powerful adults.

Within the frame of the group, they are able to come to grips with reality once more and learn to handle their inner conflicts more adequately.

The group is often blamed for creating new anxiety among its members. However, according to the foregoing elaboration, anxiety was always there. It is merely reactivated by the group and is not at all an unfavorable sign. Authors, such as Yaskin, have compared anxiety to the fever reaction in the course of an infectious disease and have pointed out the curative value of fever therapy in various disorders. As long as a patient is still capable of showing an anxiety reaction, a serious disintegration of the personality has not yet occurred, and he should react favorably to the modifying influence of the group.

Group anxiety expresses itself in a more or less sudden change of the group atmosphere. The therapist is well aware of the presence of a "group climate," which characterizes the positive or negative transference situation between the group members and the therapist, as well as among the group members themselves. If the relationship is one of mutual trust, confidence and affection, questions come readily and there is a steady flow of discussion and mutual advice. There is a happy, contented atmosphere throughout the session. Should the relationship become strained, dissatisfaction and inhibitions come to the surface.

Here are a few examples of the ways in which members of the group may indicate the mounting of anxiety:

(1) hesitation or interruption of the spontaneous flow of discussion in the group; (2) whispering, restlessness, moving of chairs, increased demand for cigarettes, etc.; (3) attempts to change the topic; (4) frequent departures for the bathroom, the patients forgetting to return; (5) frequent expressions of disapproval, such as clamoring, "griping," disapproving exclamations and loud criticism of the therapist's choice of topic; (6) continuous absence of one or several members from the group during sessions following the arousing of anxiety.

A variety of unexpected reactions is displayed by the members who do not absent themselves. Competition for the favor of the therapist, rebellion against the authority of the personnel, complaints about the hospital situation are well-known reactions, occurring in almost every group. Old struggles are revived; repressed hostility is ventilated; hidden anxiety is reactivated,

thereby creating tensions and even explosive reactions. Occasionally, certain topics will confront the patient with his faulty behavior and the false goals he has set for himself, creating a panic-like reaction.

There is an infectious quality about anxiety in one of the group members, possibly on account of the common origin of the "basic anxiety" which is present in every patient. Not even the therapist is immune to anxiety. He may find himself becoming tense and irritable and forming strong counter-transference relationships which may interfere with the therapeutic procedure. If the therapist exploits the group for his own purpose, that is, merely to satisfy his own cravings for approval and security, then he is exposed to the most disagreeable sensations and tensions if he finds himself rejected by his patients. If he is of the inflexible and aggressive type, he is unable to make concessions and cannot grasp the meaning of the anxiety reactions in the group. He is then enraged and embittered and develops additional feelings of hostility, which, in turn, generate more anxiety in himself as well as in the group.

Anxiety may lead to complete disruption of the group, which means a severe setback for members and therapist and may well plunge the patients into depression and despair. It would be quite in error for the therapist to discontinue group sessions because of the appearance of anxiety. This appearance of anxiety can be extremely valuable in the therapeutic procedure. For example: Anxiety which has been tied up in conversion symptoms, compulsions, obsessions, fugues, and even in delusions and hallucinations may again become available for constructive use and re-education. Therefore, the therapist should endeavor to guide the group members and permit them to work through the anxiety-creating situation.

Part II

Discussion of Anxiety in the Group

The writer will attempt here to give a condensed report of one of the group-sessions in which the problem of anxiety was discussed. The patients were asked which of the questions were most distasteful and anxiety-provoking to them. Following is the discussion in which the patients then participated.

Agnes M. is a 65-year-old woman, diagnosed as a psychopathic personality, who had had frequent tantrums before her admission and had attacked her husband during one of her psychotic episodes. Shortly afterward, the husband suffered a coronary attack, and the patient became depressed. This had occurred about a year previously. During the past seven months, the patient had shown great improvement, but her relatives did not make any attempt to arrange for convalescent status. The patient, a highly intelligent and good-looking woman, pretended not to be aware of her relatives' evasiveness and assured everybody in the hospital that her husband and sons could barely wait for her release. She continued to praise her husband's utter devotion and dependency on her. However, on this occasion, for the first time, the patient dared to express in the group what she had never dared to admit to anybody during a private interview.

"I'm tense," she said, "whenever anybody discusses her relatives. It makes me feel so sad. I am afraid of not being wanted, of not being loved any more. I'm afraid of not being important any more to those who are dearest to me. I'm becoming insecure and I am afraid to think that I am going to be old and lonely. I'm also afraid of poverty, doctor. It is time now to stop running away from my problems. At 65, I've got to face it! I've been afraid but now I cannot run away from myself anymore. It is time to make peace with myself. The world needs much reforming but I must do the reforming within myself."

Reda L., a well-preserved, paranoid schizophrenic, who had shown terrific hostility against her mother, against other patients, and against hospital personnel alike, then said spontaneously: "This is the same thing that makes me so anxious and tense. I'm speaking about making peace with myself. They say that the Kingdom of Heaven is within you. If I cannot solve my problems, I have failed indeed. I have found out what my soul requires but my family hasn't. I'm no success to my family. My family expects me to do too much from the financial angle. I am contented with my divine gifts. [This patient is an ardent admirer of Father Divine.] To my family I am a failure because I am reaching out for religious goods. My family wants me to reach out for material goods."

Minnie K. replied: "I think it is time for you to make peace with your family now, Reda. You and your folks are not getting any

younger. Now I wish that my husband were still alive. I guess it is too late for me now."

Anna A., a young schizophrenic girl, now much improved, becomes most anxious whenever topics pertaining to food are under discussion. She is obese and unattractive but in good physical condition and her basal metabolic rate is at the lower limit of the normal. Here is her contribution: "I've always been plump, ever since I was a child, doctor. My father used to tease me terribly. He would bring me some candy and say, 'Eat it, Annie, so you get nice and skinny.' I cried, but I could not help myself, and I ate it, and I got fatter and fatter. My father said, 'No man will ever want you, Annie, you are just too fat.' So I went on a diet and I was always hungry. One day my father and my brother ate a bowlful of spaghetti and I was so tempted that I left the table and ran out of the house. I walked down the street, crying, and I had big black spots in front of my eyes and I almost fainted. Since then, I always feel so desperate when anybody talks about food and diets."

Beatrice G. came to her rescue. "I think it does not matter a bit that you are stout, Annie, we all like you the way you are. If your glands are working all right, and if you are feeling well, it really does not matter. Is it true that when you are reducing too much, it goes on your heart?"

Minnie K., diagnosed as manic-depressive, circular type, now greatly improved, joined in: "Yes, doctor, being too heavy has always caused me lots of trouble. I do not like to be reminded of reducing diets because I've tried so many things and I'm still so fat. [This patient is only slightly overweight.] It could be that I just like to eat. You know, since my husband died, I have been feeling so lonely! And he always said that I had a beautiful figure and that I should not ruin it. He made me go to sleep with my lipstick on and he did not allow me to put curlers in my hair, even at night, so I had to do it during the day when he was away. But after he died, I sort of relaxed and I let myself go and I probably ate too much."

Reda L. suggested, "Couldn't it be, Minnie, that you were just bored? Could it have been that you were longing for love instead of food? Couldn't you get busy and do something so you would not think so much about food?"

And Agnes M.: "I think you have nothing to worry about, Minnie. You have beautiful hair, beautiful eyes—nobody thinks of your weight at all. We think you are a wonderful person."

Now Olive M., a young housewife, mother of four children, diagnosed dementia præcox, paranoid type, joined the discussion spontaneously: "What do younger people do if they are afraid of being kept apart from their children? I'm afraid they can't get along without me. Or that they will forget me and will not want me when I come back. I worry myself sick. I do not even want to listen to anybody who speaks about her children. I wonder what I shall do?"

Whereupon Rose S. replied, "You've got to take care of yourself, Olive. You should try to get well so you can go home to your children. Worrying only makes you sicker. The children won't starve. Is not your husband with them? I bet he is feeding them quite well!" (Rose is much regressed and it is surprising how much common sense she shows in tackling Olive's problem.)

Bernice G.: "Maybe praying would help. You got to have faith in yourself. Maybe then the children will not forget you. Children do not forget their mother so easily."

Sylvia P.: "Yes, Olive, you ought to have more confidence. You will get well soon."

Reda L., the one who spoke about being a source of anxiety and disappointment to her family, spoke again: "I must confess that I become very tense whenever I see the color, 'red.' It makes me sick to my stomach. Last time when you had that nice red sweater on, doctor, I had to get up and leave the room. I could not make myself come back."

Therapist: "What does the color red remind you of? Do you associate any past event with certain colors?"

Reda L.: "Yes, definitely so. When I was a child, I was disgusted with a red dress my mother bought me. She made me wear it against my will. She always wanted me to dress like a doll. So one day she again urged me to take that dress out of the closet but when I reached for it, I fell and cut myself between my legs and the blood just poured out of me. Perhaps the color red reminds me of the blood *and* the dress, I don't know. I thought that I could never stop that awful flow of blood."

Minnie K. objected: "But Reda, since you paint your fingernails red, does not the red nail polish bother you?"

Reda L.: "Oh no, Minnie, that shade of red has nothing to do with my mother!"

Therapist: "Could it be that you harbor feelings of hostility against your mother?"

Reda L.: "No, no—well yes, it could be but she is getting so old now and I ought to make peace with her. Yes, I can see where my disgust comes from, but I still do not like the color red. Believe me, whenever possible, I will avoid wearing a red outfit."

Barbara D., a manic-depressive depressed patient, much improved, talked hesitatingly about her anxiety: "I am nervous whenever I hear about operations. I had four of them. It is not that I'm afraid to suffer pains, but getting on that operating table, that's what gets me. I went through it four times. I kept myself stiff and I saw that awfully bright light. And then they put something on my face and I choked and choked. Maybe I was afraid of dying. Once when I was a little girl, I cut my head and they had to put stitches in it and ever since then, I think of dying when I hear of an operation."

Christine W., diagnosed as psychosis due to alcohol, hallucinosis, almost recovered: "I, too, am afraid of operations and sickness."

Beatrice G.: "I wonder why everybody is afraid to die?"

Christine W.: "Because you don't know what's in the other world."

Minnie K.: "What do you care what's going to happen to you after you are dead?"

Christinne W.: "Don't say that, Minnie. They say there is a Heaven and a Hell where you are going to burn forever and ever. You just can't prove it because nobody ever came back."

Minnie K.: "They say if you are cremated, that's the end of everything. Dust to dust and ashes to ashes."

Christine W.: "I wouldn't be too sure, Minnie. I am afraid to die. I pray a lot, I guess that helps me."

Anna A. (the same person who spoke about her anxiety feelings during the discussion of food problems): "I have a terrible fear of heights. I remember when I climbed up the narrow stairs in the head of the Statute of Liberty, I suddenly couldn't go ahead no more. I turned back and I was terribly scared. All these people behind me—I could not go forward and could not turn backward. I had to go on to the top and I was sick and dizzy."

Therapist: "Were you afraid of falling down or of being pushed down?"

Anna A.: "I guess I did not want to get hurt. It was not the idea of jumping or falling down."

Barbara D. became interested now: "Could it have been an old fear from your childhood days, Anna? I know that my baby was always climbing on the old bureau and was afraid of climbing down. He just stood there and yelled."

Reda L.: "I think, Anna, that that was just anxiety in you and not real fear at all, don't you think so, doctor?"

Anna A. again: "You are right. When I was a child, my mother put a pair of big slacks on me and said, 'Come with me for a walk, Annie, but you got to hurry.' So I hurried and tripped on the stairs because my slacks were too long and I fell down the stairs and I got terribly hurt. But that was only a part of my fears up there in the statue. I just can't find the right words."

Therapist: "When you were a small child, didn't you feel weak and helpless, and perhaps a little frightened? Wouldn't you have preferred to stay home that day but in order to please your mother, you tried to oblige?"

Reda L.: "Perhaps you felt bitter against your mother? Perhaps you felt trapped, somehow?"

Anna A.: "Trapped—I like that word. It just expresses what I meant before. I felt trapped up there in the statue and I did not know which way to turn. There was a big crowd of people behind me!"

Amelia S., a schizophrenic who had been working as a professional nurse, interjected: "I am afraid of crowds myself and also of elevators. I mean of riding in an elevator."

Minnie K.: "I am afraid of the crowds in the city especially when I'm riding in the subway. . . ."

Amelia S.: "Yes, there are so many people in an elevator, and the elevator is so narrow that you feel like choking. Don't you call that 'claustrophobia,' doctor?"

Therapist: "Claustrophobia means fear of being locked in or shut up—the fear of enclosed places. It is usually accompanied by a choking sensation and your heart is beating faster. Did you experience that too, Amelia?"

Amelia S.: "Yes, doctor. I felt like in a prison and then I thought of all the accidents that might happen to me. Accidents

like should the elevator fall down. That something might go wrong."

Minnie K.: "Perhaps you were merely afraid that something might go wrong with you?"

Audrey R.: "Maybe you felt insecure?"

Reda L.: "Would it have helped you if you just walked up or downstairs and avoided using the elevator altogether?"

Amelia S.: "Of course, it helped. I won't use an elevator again."

Agnes M.: "I said before that you cannot always run away from yourself. You better stop and face your problems!"

Annie F., a depressed, young schizophrenic, spoke up for the first time during the group session: "My problem is that I get scared whenever I see people getting excited. I always think that they are shouting at me. Even when I get up and you look at me, or when I move my chair, I feel tense and self-conscious. Why is that so?"

Agnes M.: "Because you are not sure of yourself. You are too bashful. We all like you a lot, Annie. You are really quite pretty. Don't be so bashful, Annie."

Roslyn G., a paranoid, schizophrenic girl, arose blushingly and said: "I have lots of fears. There is a fear of death. But I am mostly afraid to lose my mother." (This patient's mother is a highly neurotic woman who had contributed a great deal to the patient's inner conflicts.) Roslyn continued spontaneously: "I am also afraid of other people following me about and knowing so much about me and my mother."

Agnes M.: "Do you have any guilt feelings against your mother?" Roslyn remained silent and blushed. Agnes M. continued, "I think, Roslyn deserves credit for talking about her fears in front of all these people. You are very brave, Roslyn. [To the other patients:] Don't you think so, ladies?"

Amelia S.: "Perhaps you have a bad conscience?"

Roslyn G. replied passionately: "I care so much for my mother, I love her so, and the fear of not knowing if she will still be there when I come home—I can hardly stand it."

Agnes M.: "Can't you just forget about yourself and your fears and do something that will keep your mind busy? This is a big world with so much work to do!"

Roslyn G.: "I wish the other people would let me do it but they won't! They keep on watching me and follow me around."

Reda L.: "Perhaps you are just imagining that, Roslyn! Don't you think so, too, doctor?"

Therapist: "Perhaps the difficulties are not on the outside but in yourself? Perhaps you are just trying to project them onto the outside world?"

Roslyn G.: "You don't understand me,—none of you!"

Anna A.: "Oh, yes, we do. Maybe you did something to somebody, and your conscience is bothering you?"

Reda L.: "And you have guilt feelings about it."

Audrey R.: "Your mother should feel guilty that you were born!"

Agnes M.: "Stop it, Audrey! Roslyn is a brave girl. I think that she is overdependent on her mother because her father died when she was a small child. Isn't that so, Roslyn?"

Roslyn G.: "It could be so. You see, I was only a baby when my father died, and my mother had to work very hard to support me."

Reda L.: "Perhaps she got on your nerves like my mother got on my nerves with her love and her kisses. Don't they call that 'smother-love,' doctor?"

Bernice G.: "Don't say you don't like your mother, Reda. I wish that mine were still alive; I sure would need her now. But I agree with Agnes and think that you ought to become a little more independent now!"

Roslyn G.: "Thank you all, girls, for your kindness. I'll take a job when I get out of here. That will give me something to do." (The patient had never worked in her life.)

Therapist: "The time is running short, ladies. I just want to ask you one more thing. Why didn't you like the topic about planning for your old age? Why did so many of you check out and stay away from our session when we discussed the plan for building an old people's home and how it should be furnished?"

Agnes F.: "It's the fear of getting old and the fear of not being wanted any more."

Reda L.: "As a child, I was afraid of the boogey man. I still am. I was a beautiful model when I was younger. I don't like the idea of getting old."

Minnie K.: "I could not attend your session, doctor, because I had to go to the rehearsal for the show."

Reda L.: "Don't evade the issue, Minnie."

Anna A.: "I'm too young to think about an old age home."

Agnes M.: "How dreadful to think that one will be old *and* mentally sick."

Olive M.: "I hate to think that my family might put me away when I get old."

Ida S.: "I'm more afraid of not being loved any more when I'm old and sick."

Amelia S.: "Elderly people get so funny, they shouldn't be moved around. Who wants to go to an old age home!"

Reda L.: "I hate to be shelved. They place a stigma on old age nowadays."

Amelia S.: "When you get old, you don't talk so nicely in company any more. I mean, you can't make conversation, and they don't invite you to parties any more."

Reda L.: "They say we are a young country and that we don't have any use for old people. I used to be a model but I won't be able to compete with young people. There are always younger and more beautiful ones. One should cultivate one's mind when one gets older and not one's body." (Reda was one of the patients who stayed away from the group for many weeks after the discussion on the topic of old age.)

Part III

Conclusion

The group provides an effective testing ground for social readaptation, and is of great value to the patients as a preparation for their convalescent period. Through proper guidance, anxiety will be overcome or put to constructive use by channeling it in the right direction. Many of the anxious patients were bitter and withdrawn before joining the group, but as soon as they overcame their mental isolation, they were able to bring their conflicts to the surface, whereupon their anxiety diminished rapidly. Many group members were able to leave the hospital at a much earlier date than had been expected before their participation in the group.

Patients like Agnes were able to express problems in the group about which they did not dare to talk during the individual interview. Obese patients like Anna and Minnie expressed their feelings of inferiority about their appearance. Minnie was made aware by the group of the underlying, unresolved conflict and the anxiety that caused her to overeat. Her craving for love was well

pointed out by one of the members, and she was not able to face the problem squarely and plan constructively for her future. Anna, the other obese girl, was too anxiety-ridden to stand analytical interpretation of the problem and had to be reassured—or her anxiety feelings would have become unbearable. This was anticipated intuitively by some of the group members who reassured this patient about the good qualities of her appearance and character.

Problems such as hostility feelings against members of the family lost much of the embarrassment and anxiety they had caused to such patients as Reda and Roslyn, and the patients were enabled to adopt a more mature attitude toward their problems. Minnie's and Roslyn's anxieties were turned into socially useful channels—by getting them interested in taking a job once they were sent home.

Social reality is always present in the group, and the members have ample opportunity to gain insight into the bizarre character of some of their fears, which are now clearly perceived as anxiety. Even delusions such as Roslyn's persecutory ideas were criticized and corrected by the members. Some of the patients will react very favorably to the criticism of the group and will put their anxiety to constructive use.

Anxiety in the group, therefore, does not have to be a destructive force but can be used constructively for the purpose of increasing self-esteem, self-realization and enrichment of the personality.

The writer has attempted to give a condensed report of one of the group sessions in which anxiety-arousing topics were discussed. One cannot expect patients to derive a great deal of benefit from a single session, but one does find in the session a few indications of the ways and means by which group psychotherapy may help the patients.

Summary

Part I

This paper surveys: the origin of anxiety, basic anxiety; anxiety in the neurotic and psychotic patient; the group as representation of the family situation; the prognostic value of anxiety in the group members; the group climate; the effect of anxiety on the group members and therapist; and the utilization of anxiety during the therapeutic procedure.

Part II

Discussion by the group members of anxiety-provoking problems in a group psychotherapy session is reported.

Part III

The conclusion is reported that anxiety can be mobilized and utilized constructively in the group situation.

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AN EXPERIMENT IN TREATING SERIOUSLY DISTURBED JUVENILE DELINQUENT BOYS*

BY BENJAMIN HILL, Ed.D.

Six years ago (on January 6, 1947) the Annex of State Training Schools for Boys, at New Hampton, N. Y., first opened its doors and received five boys from the New York State Training School for Boys at Warwick.

This unit for the treatment of seriously disturbed juvenile delinquents had had a long gestation period. As early as 1942 thought was given to the problem of how to treat seriously disturbed adolescent boys in the two New York State training schools (the State Agricultural and Industrial School in Industry and the Training School at Warwick). In each school, the presence of a small, difficult group of highly-disturbed boys constituted a threat to the open program and comparative freedom of the cottage system which, through the years, had come to be accepted as the basic pattern for institutional treatment of delinquents.

From 1942 until the opening of the annex five years later, much exploratory thinking occurred. In February 1945 the interdepartmental committee appointed by Governor Dewey and consisting of commissioners of the state departments of Education, Social Welfare, Correction, Mental Hygiene and the State Parole Board, published a report. This report specifically recommended that specialized facilities be established for juvenile delinquents who were runaways and overly aggressive, and who could not be cared for in an open type program.

While the emphasis in the thinking which resulted in the establishment of the Annex was upon physical security, equally strong consideration was given to exploring the extent to which constructive treatment and rehabilitation could be carried on within the framework of a security setting. It was believed from the start that a small security unit offered the opportunity to study at close range both the problems of seriously disturbed boys and the treatment measures which might be brought to bear on their problems.

Because the Annex was an experimental program, it was set up in buildings and grounds leased from the New York City Department of Correction's reformatory at New Hampton. The main

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building contained individual cell-like rooms opening into a long corridor. Another building contained classrooms, vocational shops, and a gymnasium. Barred gates controlled the entrances to the dormitory buildings, and to each wing. An eight-foot cyclone-type fence, topped with barbed wire not only surrounded the leased area, but also separated the dormitory building from the educational building. It should be noted parenthetically that the leased buildings were physically isolated from the other reformatory buildings.

As the program began to develop, it became clear that while physical security is important, it does not constitute a process. Security can and should play a role in treatment, but treatment cannot play a subsidiary role to security.

In working out the program, it was felt that the most could be accomplished by subscribing to the "problem approach" to the difficulties presented by the boys under care.

The boys at the Annex have always been looked upon as being young men with problems. Problems invite solutions. Solutions require data. Collection of adequate data requires objective study. Study leads to understanding. Understanding encourages the resolution of problems.

The "problem approach" further enabled staff members to say to a boy, "We may dislike intensely many of the things you have done and may be doing, but that does not mean that we dislike you as a person."

There were certain factors which helped to put this problem approach into action. One of these was the policy that the basic working unit should be no more than 10 boys to a staff member; others were a case load of 20 boys to a psychiatrist, 30 boys to a social worker, and a class size of 10 boys to a teacher.

Another positive factor was the staff acceptance of the philosophy that boys coming to the Annex should be treated with kindness and understanding (that is, as human beings should be treated).

The writer considers this personal relationship factor to be, perhaps, the most important single factor which is at work at the Annex. The size of the Annex, the small size of the living, work, education and play groups, have allowed this factor to achieve optimum effectiveness. Visitors, without exception, first notice the grimness of the buildings, but they are not there long before these first impressions begin to fade. They begin to pay more at-

tention to the spirit of co-operation and friendliness, and to the understanding that fills the air.

A concern for personal relationships usually indicates recognition of the importance of the individual as a person. Consideration for the individual as a person involves the effort to help him understand his problems. It is felt that our clinical services represent an important resource for helping the boys toward a better understanding of themselves and the staff toward a better understanding of the boys.

The Annex's clinical facilities consist of two social workers, three part-time psychiatrists (allowing three days of psychiatric service each week), a psychologist who provides one day of service each week, a part-time medical doctor, and a dentist.

A very important function of the social workers is informing the staff members of a boy's social background and the apparent influences of circumstances upon his development. The social workers, because of the small case load, are able to provide maximum counseling service for boys and staff.

The role of the psychiatrists will be outlined further on in this paper.

A diversified program is another important factor. The boys at the Annex spend their waking hours in work, education and recreation.

Work activities involve not only the routine tasks of an institution, but also many jobs which may have trade-training value.

The educational efforts are aimed to start from the points the boys have reached and, by capitalizing on their interests, develop a program which will help them to learn some of the skills necessary in daily living. The school includes two academic classes, an excellently equipped woodworking shop, a general shop in the process of being developed, and a remedial reading section.

A varied recreational program has been established. Directed activities are scheduled from 5:30 p. m. until 8 p. m., Monday through Friday. The boys' recreation committee works closely with the staff recreation personnel in suggesting and evaluating program content. Four recreation areas are in use each of these evenings. A gymnasium is used for active large-group games; a rumpus room for pool, ping-pong, weight lifting, body-building, boxing and training types of activities. Quiet games and activities are scheduled for the lounge room; and the television set, given

to the Annex by the Junior Leaguers of Middletown, N. Y., provides a program for the fourth area. The boys have a free choice of activity on week-ends and also when they are in their living quarters. A number of hobby groups have been sponsored. Some outstanding work has been done by the Boy Scout troop, the Barbell Club, and the garden, 4-H, airplane, and entomology clubs.

Some other important characteristics of the Annex are the use made there of positive motivations, the employment of consistent pressures, the use of interviews to reduce hostility and last, but by no means the least important, religious counseling.

As the program developed, it was found that significant modifications could be made in the security features. These were begun by leaving open the bar gates to the entrances to the wings at certain times. Finally, all of the bar gates were removed from the dormitory building. Next, the fence which separated the dormitory building from the education building was removed. All changes in the physical security features were brought about through the co-operation of the boys and the staff. The staff and boys, as a result of this working together, grew to feel that they had a stake in the project.

About two hundred different boys have been transferred to the Annex since the time it received the first five boys from the Warwick training school on January 6, 1947.

Transfers from Industry and Warwick (hereafter referred to as the "parent institutions") are made by the commissioner of the New York State Department of Social Welware only after careful review of each case by the department. These cases are carefully screened for admission by the case committees of the parent institutions, and by the staff of the Annex as well. A few cases have been received from the New York State Department of Correction by use of the interdepartmental transfer law.

The problems of the boys transferred to the Annex are similar to those of other boys in the training schools, but are more severe.

A study made of the first 68 showed four main reasons why transfers were requested; running away, agression, sex problems, and personality disorders. Analysis of 64 recent admissions indicates that running away, aggression, and serious personality problems continue to receive major emphasis among the reasons for transfer. Upon comparing the two analyses, one cannot help but

be impressed with the increased mention of serious personality problems among the reasons.

Among those with personality disorders, have been boys who had been diagnosed as psychopaths, pre-psychotics, and schizoids. The following have been mentioned as serious personality problems: tantrums, anxiety, withdrawal from reality, hysterical compulsions, guilt reactions, insecurity, impulsive outbursts, symptoms of epilepsy, emotional immaturity, ideas of persecution, and suicidal attempts.

The reasons for transfer of two boys who arrived at the Annex in September may serve to illustrate the nature and the severity of their problems. These are typical cases.

J. S. This boy has run away repeatedly and has a long history of running away; he has exhibited tantrums and other aggressive and rebellious behavior from an early age, and this behavior has continued. He has resisted authority and plotted with other boys to run away; he has made two suicidal attempts. He has shown no evidence of emotional disturbance over his acts or any guilt or remorse; he has the defective judgment and egocentricity of a psychopath; he needs custody and close supervision over an extended period of time in a security unit.

G. L. G. L. presents serious personality problems characterized by tantrums and assaultive tendencies. On two occasions he has planned assaults on cottage personnel in connection with running away. Although these planned assaults have been discovered in advance and prevented, the boy continues to be a dangerous individual. He requires close supervision in a security unit.

An attempt is made to show the boy, right from the start, that he is not in a "Little Alcatraz." The reception procedure at the Annex is very brief--a matter of one to three days. This is because it is felt that the boy transferred to the Annex has been "received" enough. All the staff wishes to do is to get him relaxed, acquaint him with a few of the routines, have him see a few key people about program and routines, and have him observe such activities as school, work, recreation, and eating. This observational tour often may be done in the company of another boy. A wing reception committee tries to make the newcomer feel welcome on the wing. While this is going on, one of the two social workers prepares a "high-spot sheet" for the benefit of those staff members who may work directly with the boy. It outlines a few of his

strengths and weaknesses. Daily reports are filed in the boy's reception folder. The boy's social worker summarizes the results of the brief observations. Placement in the regular program is then authorized.

By referring to a summary report, one could find some of the following information about a boy. Let us take the case of R. A. He arrived at the Annex September 22 at 2 o'clock. There were no unusual incidents regarding the actual transportation. He met his psychiatrist, each recognized the other immediately. The psychiatrist remembered having examined R. A. for the Children's Court, and also had known R. A. at the Children's Group at Rockland State Hospital. R. A., as a result of his tour, felt that he would like the school program and especially the vocational shop. "Daily Living," in its contacts with R. A., did not find anything unusual in his behavior. He did not wet his bed; he ate and slept well and seemed generally accepted by the other boys. (At this point, one should digress to make a brief statement about "Daily Living." This is the section of the Annex which provides the basic training for a boy at the Annex. The supervisory staff all function in this section.) R. A.'s social worker found the boy reasonably at ease, also felt that R. A. showed lack of judgment, poor reasoning, and a tendency to lack perseverance. It was felt that R. A. should be regarded as a runaway risk. The social worker completed R. A.'s summary by recommending placement in the regular program.

The statements from this report may serve to indicate that the team work progress of the Annex is already beginning to function on behalf of the boy. The chaplain, teachers, supervisors, social workers, psychiatrist and psychologist act as resources for the development of a program of living which may be most helpful for a particular boy.

After a boy is placed in the regular program, he is considered to be in an orientation period for approximately two months. A part of his program during this time involves not only school, work, and recreation, but also an orientation session with his social worker. This is usually a group meeting. These meetings are designed to inform and orient the boys to an easier adjustment to Annex living. It was found that rather often information given to the boys in the brief reception period was forgotten in subse-

quent weeks. It was also found that the information given and discussed in these meetings was more meaningful to the boys after they had had some experience in the regular program.

Additional effort is made, especially in the first month of a boy's stay at the Annex, to establish the treatment framework within which the staff may operate with this boy. The thinking of the various people is drawn together at the end of the first month.

The report at the end of this first month is rather thorough. Let us take the case of I. W. by the way of illustration. From his report, it can be seen that he is a boy of average intellectual ability. His psychiatrist finds him rather stable and predicts that he will adjust well to the Annex. The psychiatrist suggests further that I. W. be assigned mostly to work in our woodwork and general shops. I. W.'s social worker reports that he carries on very active correspondence with his family. These letters seem to indicate a close, warm feeling within the family, even to the point of the parents' being somewhat overprotective of I. W. The teachers find him to be quiet, friendly and co-operative. Both shop teachers report good response to all projects and that he is developing skill in hand tools and in the use of machinery. The supervisors also find him to be quiet, friendly and co-operative. They indicate that he is highly active in recreation. However, the supervisors feel that they have not gotten to know him very well, that he seems to be rather weak and is afraid of some of the boys. However, I. W. has responded well to supervision so far, and they feel that eventually he may develop a more trustful attitude toward adults. The final recommendation is that the staff continue to encourage him in his shop assignments; also, that they use a consistent, adult type of approach with him.

Less intensive evaluations will occur at intervals of approximately four months apart. These are not very detailed until it appears that a boy is ready for parole consideration.

The system of reporting involves the use of logbooks, observation reports, factual reports in relation to certain incidents, and oral reporting by any of the staff members who deal directly with the boys to the head children's supervisor on duty. Both teachers and supervisors are required to make entries in the logbooks at the conclusions of their tours of duty. Here are some examples of log reporting, taken first from the senior boys' supervisors' logbook and second from the teachers' logbook.

Supervisors' Log: October 23, 1952—8 to 4:30—painting all day on school building. J. P. best worker and showed most skill. S. K. doing much better than usual. R. J. trying hard but little or no skill being shown. J. R. keeps plugging, with little skill. R. R. showed poor attitude but apologized and showed marked improvement after being talked to. Relieved on wing 2 at noon. Cleaning satisfactory. Program orderly. No incidents.

Teachers' Logbook: October 17, 1952—Encountered some minor difficulty with R. L. and J. S. Not serious. Boys playing and wasting time. C. W. playful and a trifle noisy. Otherwise session o. k. General shop: Boys seem to be noisy and jumpy. One interruption. P. W. refused his assignment, and called L. O. a ——. Case referred to Head Children's Supervisor who had a talk with P. W. Woodworking shop: Group 1 still showing good co-operation and interest. G. A. late to class. G. A. showing good reasoning ability on project work. Group 3 restless at first, but settled down as period progressed. Caught R. P. writing note during class. Boy at first lied, saying it concerned tool room. Finally admitted it to be a note, but did not discuss it any further.

All of this report material, whether it is in a logbook or in memorandum form, or given orally to a head children's supervisor, is channeled into the general office and studied each day by the assistant director. This is for the purpose of establishing an agenda for the daily adjustment committee meeting which takes place every afternoon.

The work of the adjustment committee, whose membership is made up of the director and assistant director as co-chairmen, and the head children's supervisors, with the head teacher and the boy's social worker acting as consultants, has proved to be one of the greatest factors in getting a boy off to a right start.

The committee, when a boy is in the regular program, continues to work closely with him as a result of constant verbal and written reports, both favorable and unfavorable. Most rewards are granted through the adjustment committee; all curtailing of privileges is administered by the adjustment committee, usually only after maximum effort has been expended in boy-staff and boy-adjustment committee consultations.

On some occasions, the adjustment committee is moved to deprive a boy of all program privileges. This is usually done if a

boy's behavior is such as to make him a menace to other boys and to the program. It is also done only after other measures have been tried and found wanting at the time.

The basic function of the adjustment committee is to avoid discipline by a staff member acting as an individual and to make certain that any punishment administered is done after careful consideration. The committee, acting as a group, has not only helped a boy time after time, but also has stabilized a staff member.

A boy's psychiatrist, very early, begins to play a major role in the boy's life at the Annex. Our three part-time psychiatrists, who each give one full day of psychiatric service each week, have found, on the whole, that the attitude of the boys at the Annex is more accepting toward clinic help than is reported by therapists in other similar institutions. In most cases, the majority of the boys request interviews. Rarely does a boy refuse to see his psychiatrist. On one or two occasions a boy has not been able to form a transference and has asked to see another psychiatrist.

The psychiatrists, in considering the number of cases that they feel have required individual and very active psychotherapy, have found that approximately two-thirds of the boys were severely disturbed and needed this frequent attention. It is also their opinion that individual psychotherapy is the more appropriate type for such a small group of boys as that at the Annex, especially for severely disturbed cases. They feel that group therapy may be more appropriate in very large institutions where it is impossible to give individual psychotherapy in large numbers of cases.

Two of the Annex psychiatrists have attempted some group therapy. The experiences have been too limited to permit any definitive statements except that group therapy should be considered as a supplement to individual psychotherapy and not as a substitute for it.

Other forms of treatment used by the Annex psychiatrists have been sodium amytal interviews, where indicated. One case of psychosis with mental deficiency was treated with ambulatory insulin which resulted in a complete loss of hallucinatory and delusional material and brought the boy back to reality.

It is the general impression of the clinic personnel that psychotherapy has contributed materially toward the adjustment of a good percentage of the boys treated; also, that the clinic has further contributed to the treatment of the boys by consultative serv-

ices to the Annex staff. Every staff member has access to psychiatric consultation. This has enabled the program at the Annex to be carefully planned on a psychiatric treatment basis; and each boy, in a sense, is placed in a 24-hour treatment situation. The psychiatrists report that the boys have given direct appreciation of the benefits of this treatment by stating, "We improve at the Annex because there is always someone to guide and supervise us. We cannot make a false step without being set on the right track whereas at other institutions there were so many of us that there were not many supervisors who could help or talk to us."

The Annex psychologist has helped the program in many ways. There is a testing program which is generally similar to such programs in other institutions; but over and above this, the Annex psychologist is beginning to play a major role in our remedial and vocational guidance programs.

After a boy has been at the Annex for two months, he becomes eligible to receive family visits. Eight months later, assuming that a boy has made a reasonably good adjustment in the closely knit and intimate living situation, he becomes eligible for "off campus" privileges.

The off-campus program represents a vital part of the total program. These privileges were initiated because it was felt that such experiences would aid the boys in their return to constructive living in their communities. Some people were skeptical when this phase of the treatment program was begun because they felt it represented too great a disregard for the importance of physical security features. Yes, this was a long step from the original emphasis which was placed on physical security. However, the Annex's experiences should serve to indicate the degree to which boys with serious social and emotional problems respond to the program even when that program takes them away from the physical controls of the institution itself.

The following are examples of some of the community contacts which occurred during the month of February 1952: February 4—Annex basketball team played in Y. M. C. A. league game in Middletown; February 15—Some boys attended a talent show at the A. M. E. Zion church in Middletown; February 19—A group of boys went to Goshen to attend an assembly at the high school.

What gains does the staff feel have been made as a result of the community contacts? First, and foremost, are those which are

recognized by the boys. They have found out that there are some adults in this world who are intensely interested in their welfare and are willing to help them. These contacts have helped the boys develop poise and confidence in their ability to meet people. They also gain in self-respect because they find themselves accepted as individuals participating in a normal community experience. Many of these boys have felt themselves apart from the world. Community contacts now help them to feel in tune with the world.

The staff members, too, have gained from the off-campus program. They have had many opportunities to observe the Annex boys in a wide variety of normal community situations. Their relationships with the boys have been enhanced because of the more relaxed atmosphere which is present off-campus.

The Annex as an institution has gained. Its gains are those which have been mentioned by both the boys and the staff. In addition to these, the staff has become aware of increased resources existing in the surrounding communities which can be brought to the Annex in order to enrich the on-campus program. A point has been reached where the communities have lost much of their hostile feeling toward boys in training schools. This, the staff feels, is because people have had a chance to get acquainted with their boys.

The total organization at the Annex, all of its activities, whatever may be done, is heavily weighted in the direction of encouraging the development of personal relationships, between the boys themselves and between boys and staff. Perhaps some statements from the boys may serve to illustrate how they feel about this matter of personal relationships:

"Doc, this is what you might call a letter of thanks for what you and the staff at the Annex did for me. I learned that no matter how big or how small a guy can be, if you don't know how to live, play, work and get along with everyone you just aren't human."

"Time and time again I think of the Annex. Some of the fellows might say I am joking, but here is the real feeling I have. The greatest responsibility the boys have there is to get along. Sometimes I wish I was back there with Big Red, Mr. Nolan, and Mr. Ben Graziano. I have really seen some great times there and I am dying for some of Mrs. Nolan's, Mrs. Catlett's and Mrs. Hill's cooking, and one of my favorite cooks, Mrs. Graziano."

There is a continuing effort to explore ways of establishing better relationships between the boys and the staff. Lessening the gap between those two groups is a problem which must receive serious consideration on the part of all. The writer does not suggest that this gap should be completely wiped out, but certainly there should be bridges across it for communication. One problem is how to build these bridges; and one way seems to be through the building up of an understanding by both boys and staff of the role each has to play in living at the Annex. There should not be complete staff dominance and boy submission, nor, of course, should there be the reverse, boy dominance and staff submission. The burden of building these bridges, or of finding ways for establishing better relationships between staff and boys, rests mainly on the shoulders of the staff. Each staff member is encouraged to be alert to finding ways of getting boys to work with him, rather than always either doing things to the boy or for the boy.

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I interrupted my writing at this point to watch a group of five or six boys returning from an off-campus trip. They had been to see a local football game with a couple of staff members. I overheard some of the talk about the game. Here had been another chance, I thought, for staff and boys to see another side of each other. They had experienced something in common. Here was one of those "bridges."

Also, as I continued my writing, I could hear a variety of sounds coming from the wings. It was Sunday afternoon; the afternoon program of "choice activity" had ended. The boys were in their living quarters for half to three-quarters of an hour before going to supper. A saxophone gave out its reedy tune, a piano was being played, radio music, conversation and laughter filled in the background. I knew that some fellows were in their rooms reading, writing letters, or just resting, others were sitting in the lounge areas of their wings, visiting with their friends, and still others may have been playing a fast game of pinochle. Such relaxed times as these, where the pressures of institution living are least, are important in the treatment program. A boy can retire to his room if he wishes to be alone for a while. He knows that his time is his own. I often go to the wings at such times, for this provides the boys with an excellent chance to bring me some of the problems which are of concern to them. It is one way of letting the

boys know of my interest in their welfare. Other key persons do the same.

It was such a tour on a Saturday night that gave me a chance to listen in on a meeting of a wing council. Each wing has a council. Its purposes are to provide the boys with opportunities to air their likes and dislikes, evaluate programs, suggest new ideas, all within the framework of a few simple rules for conducting meetings. K. N. was the presiding officer; and you might say, "Well, what about it?" The strange part of this is that K. N. was about the last person you would have said could do a fair job of running a meeting. Quiet, shy, never outspoken, a good worker, K. N. was an unknown quantity. What a difference there was as president of his wing. He conducted that meeting with assurance. He was objective and firm. The other fellows respected his sincerity. K. N., when I arrived, had just opened discussion of the wing talent contributions for the Annex Hallowe'en party. This was followed by a discussion of a complaint of unfairness which some wing member had lodged against the wing basketball captain. K. N. was like a moderator at a UN meeting. He gave both sides a chance to air their views. I found out on the following day that the wing gave the captain a vote of confidence of 16 to 5.

So it is that a boy progresses through the program, living, learning, playing and working. All of his experiences have been geared in the direction of providing a firm foundation on which to base his re-entry into normal community living. The average boy who arrives at the Annex, usually just prior to his sixteenth birthday, now is 18 or pretty close to that age on leaving. All the time he has been at the Annex, his parent institution has been kept informed of his progress through visits made to the Annex by the parent institution social worker and/or by means of periodic reports sent to the parent institution. At the time of the boy's release, responsibility for him then returns to his parent institution for the carrying out of a parole plan, for the Annex has no aftercare service of its own.

What some of the boys think has been done to help them may best be expressed by citing excerpts from letters which I recently received from two of our graduates, one of whom is in the air force, and the other in the reception center at Elmira. I quote,

first, from the air force letter which contained a message for all the boys at the Annex.

"I hope all you boys that are at the Annex could realize the importance of the staff members' help as your guardians because they are your guardians. It makes no difference what you have done, or have been through because there is no place in the world for someone who pities himself. A man needs friends because without friends he is lost. You are there at the Annex for a reason and that reason is because you have done something for which you deserve punishment, but the staff at the Annex are not there to punish you, but rather to help you as they would help their own children. Don't turn away from them. Go to them for guidance. Don't be afraid because they can help you more than you can help yourselves."

I now quote from the reception center letter, which indicates that we do not have all the answers.

"Just a few lines to let you hear from me. I am fine and getting along all right. I really miss the Annex. It is really a great change in things up here than it was at the Annex. What I mean by that is things at the Annex that I liked I don't have up here. I just want you to know that I appreciated the Annex very much while I was there, even though I got into little troubles now and then. I hope that when I come home again I will learn the things that you and all the other staff members that worked with me tried to make clear. Dr. Hill, I think that the Annex would have benefitted me much more if I would have stayed there for a longer period. Will you give my regards to Mr. Eklund, Mr. McKeiver, Mr. Warner, Mr. Filander, and Mr. Kerfoot. Dr. Hill, I know that everyone at the Annex was interested in helping me but then I just didn't give them a chance. It is a funny thing when a person don't listen he always goes wrong but, Dr. Hill, I intend to make this time that I have the best that I have ever served. I have a very small bit of time, 2½ to 4. I am still taking care of my body and trying to learn more mentally as physically. Give my regards to Chaplain Magnan. I miss my barbells that I used to like to lift so much. I saw a couple of fellows that was there at the Annex the time I was there like R. B., J. M., L. J., and others. They have recommended me for State Prison. If you write me back I know they will transfer the letter to me. I remain your friend."

The writer has included this letter because, in his opinion, it raises the question that even for such a boy, who statistically would have to be written off as a failure, is there not evidence that he received some worthwhile experiences at the Annex which may yet prove to have been a positive factor in his life?

The Annex of State Training Schools for Boys
New Hampton, N. Y.

DISCUSSION

(Of Preceding Paper by Dr. Benjamin Hill)

BY E. R. CLARDY, M. D.

When the Annex of State Training Schools for Boys was organized in 1945, the New York State Department of Social Welfare had considerable understanding of the emotional difficulties presented by the boys and therefore realized that they would probably require considerable psychiatric attention. Consequently the welfare authorities wisely sought help from the Department of Mental Hygiene. It was realized that in order to make an accurate evaluation of the treatment facilities required, it would be necessary to make a psychiatric survey of the residents of the Annex. Consequently the writer, in company with Max Unger, M. D., was selected to make this study.

The results of this examination disclosed that approximately two-thirds of the boy residents had been placed, according to their previous histories, in the category of chronic psychopathic personalities. The majority of them were emotionally disturbed to the extent of requiring intensive psychotherapy. Consequently the Department of Social Welfare established a clinic set-up composed of three psychiatrists, each giving one day a week to the clinic at the Annex. Therefore, in comparing this with the clinics of other similar institutions, it appears that the Annex affords far superior psychiatric facilities. As mentioned by Dr. Hill, the clinic has already administered such major treatments as ambulatory insulin and interviews under hypnotic drugs. In fact, the clinic is prepared to meet almost any psychiatric problem that arises. For instance, recently, a boy who was starving himself required tube-feeding. If it were considered necessary and advisable, the psychiatrists are equipped to give even major shock therapies.

At the Annex, in the beginning, as in many places, there were, no doubt, staff members who had at first very little understanding of psychiatry. Psychiatry had to do with "crazy" people; it was considered in terms of unreality, as something mythical or magical; but now the psychiatrists feel that they are considered as just fellow-members of the treatment team and as consultants in the planning of the boys' daily living and growing at the

Annex. Also, it is recognized that the psychiatrist is a physician who may aid staff members with their own emotional problems; for it must be remembered that staff members, as well as boys, have their own individual problems; and the future welfare of the boys may depend considerably on the good adjustments and healthy personalities of the staff.

The clinic has attempted to make the staff feel that it is not something separate and apart from them, but that staff members take an important part in the treatment program. The psychiatrists realize that they are not the only ones that give psychotherapy. Therefore, at the Annex, psychiatric treatment does not stop with the psychiatrists; it is carried on in daily living, in the school, in the living quarters, during the day and at night.

Although individual therapy with the boys is very important, one of the major functions of the clinic probably consists of establishing and coordinating a supervisory psychiatric treatment situation. This means an educational program whereby the staff in general receives a better psychiatric orientation, including an "in-training program."

Before one can discuss what psychiatrists are doing for the boys at the Annex, let us consider the type of boy that one has to deal with. As mentioned, it was found that before coming to the Annex, the majority of the boys were considered as not only psychopathic personalities, but their prognoses were considered practically hopeless. The prognosis in many such cases contained statements such as: "It is doubtful that this boy will ever make a satisfactory adjustment. He probably will be in and out of institutions for the rest of his life. He appears entirely unable to learn by experience." Before coming to the Annex many of the boys had been treated in institutions a greater part of their lives, as long as seven or eight years.

It appears to the psychiatrists that one of the most important sources of information concerning their problems should come from the boys themselves. Consequently, one finds them giving voice to such evidences as follow:

"I think I would have been different if I had a home of my own. I never knew what a real father and mother was. I lived in foster homes all the time. I ran away because I wanted to be in my own home. Maybe I would have been different if my father and mother had watched after me closer. I hardly saw my father. He was at work all the time. He didn't even give me a lickin' when I got in trouble." (Meaning that the father gave him practically no attention, not even a licking.)

"I wasn't happy at home. My mother and father were fighting and quarreling. They separated and both of them married again. I never had the things that other boys had—only old, cheap clothing. I didn't have money to buy sodas and go to the movies so I started stealing and robbing."

Other answers were: "Maybe a boy gets into trouble because a parent doesn't understand him." "I got into trouble for fun and excitement." "I wanted to be like other boys." "I wanted them to think I was a big shot."

In relation to the treatment and what is being done for the most difficult boys, it has been mentioned that the nature and extent of their problems prevented their adjustment in institutions where they had more freedom. In other words, it was necessary to give them security before it was possible to treat them. It was necessary to hold them, even to the extent of locking them up in a sense, before one could treat them. In previous institutions, the large size of these prevented emotional security, as noted again in the verbal productions of the boys, "I got along better at the Annex because it was too big at those other places. Here people talk to you, say 'hello' to you and be nice to you. I guess they don't have time in bigger places. There are too many boys."

Such a production implies that too much freedom to this type of boy means insecurity. Such boys were often insecure in their own homes where they had lack of supervision and too much freedom. An open institution, therefore, presented practically the same situation to them that they experienced while at home. The aggressive individual who seems to have little control over his impulses seems to like firm, authoritative people to care for him; he knows where he stands, this gives him security. On the other hand, the Annex staff members realize that they cannot be hostile and punitive in their attitude, since, although the boy may be controlled by punitive methods, he will only bury his hostility, which may reappear in a more destructive form.

Also in relation to guidance of treatment, one looks to the productions of the boys. For instance, a boy states that he did things because he wanted to be a big shot and do things other boys did, that he didn't do well in school and played hookey. Consequently, at the Annex, it is attempted to give him this necessary status in a constructive manner. For example, a boy who was inferior in body build as well as in school work, took up weight-lifting and, by developing his physique, gained status through this accomplishment. One boy who is dull and has difficulties in competing with other children in many lines, gets great pleasure and is looked up to for his ability in singing cowboy songs.

The feeling and sense of security among the boys is rather striking and is frequently mentioned by new psychiatrists coming to the Annex. They note "that the boys seem to have a feeling of being accepted and wanted."

Individual psychotherapy, especially with boys who are considered very disturbed, is certainly indicated, and apparently there has been considerable success with this form of individual psychiatric treatment, which is illustrated in the following instances:

One boy was diagnosed as a very severe case of mixed psychoneurosis and was certainly an acutely psychotic individual. On admission to the Annex, he was in a disturbed, hysterical state. He trembled to such an extent that he couldn't feed himself. It was noted that he previously had actually had a hemorrhagic ulcer of the stomach and had required an emergency operation. After his operation, he had remained in a state of panic. He was fearful of eating food or undertaking any work. He was sure that he was going to die and that he couldn't possibly remain at the Annex. After a few months of intensive psychiatric therapy in conjunction with the co-ordinated and understanding treatment afforded by the staff in general, his symptoms have now practically subsided. He is a calm and quiet boy who now happily participates in most of the activities of the other boys. He is not afraid of ulcers, and is in fact, a *hearty eater*.

Another outstanding case was that of a 16-year-old boy who had stabbed a younger child. Practically nothing had been learned concerning the etiology of this boy's problems before he came to the Annex. Apparently he blocked, or had forgotten, or had repressed thoughts connected with the crime. He apparently made a very good adjustment during the beginning of his treatment at the Annex; however, nothing had been learned about him. The entire staff believed that his adjustment was only a superficial manifestation. Results of individual interviews were proceeding very slowly. Therefore, it was decided the process should be hastened by interviews under the influence of hypnotic drugs. Consequently, the psychiatrists instituted intravenous injections of sodium amytal, following which it was revealed that the stabbing incident was a schizophrenic manifestation. He had pictured himself "as a commando who was stabbing a slant-eyed Jap." These interviews were continued until it was felt that most of the unconscious repressions had been revealed.

Following interviews, a great deal of anxiety was created in the boy by making him face reality and realize the implications of his crime. (On the outside he had been told to forget everything concerning the crime, that it would never happen again in a thousand years.) After this period of anxiety, he made a steady improvement and a more normal contact with other boys, whereas previously his contacts were superficial and showed no evidence of warm human interpersonal relationships. After a three-year period of relatively good adjustment, the boy was released. He joined the navy and has made a good record for over two years.

Although the writer does not wish to minimize the importance of individual psychotherapy, it is felt, on the other hand, that the major treatment factor is that given as a co-ordinated unit by the staff as a whole and by the placing of the boy in a secure and psychiatrically-oriented environment—the giving of an opportunity to make parental substitutes with desirable persons. This is a slow re-training program, whereby a boy is

helped to extend his arms and reach out to some interested staff member who is in turn reaching out, until some warmth is established between them, and finally, a healthier social understanding is developed in the boy. The program and treatment at the Annex is directed so as to foster growth and maturity, to give the boys some understanding of acceptable social standards.

Eventually, there is the problem of placing the individual back in the community. This is frequently a discouraging and difficult task, for there is the danger of placing a boy back in the same old sordid, traumatic environment that produced his difficulties. Frequently, it is necessary to retain him a year or so longer than would otherwise be required, because a suitable placement cannot be found. It appears that some sort of organized foster home or intermediate institution should be prepared for such cases.

Finally it is difficult to make a definite estimate, from a statistical standpoint, of the results of treatment at the Annex, especially since there has been no detailed follow-up study. On the other hand, it is known that a good percentage of the boys make a relatively good adjustment while at the Annex. Also in view of the very poor prognosis previously given to their diagnostic category, it seems that if only a reasonable minority continue to adjust, the state will be saved money; loss of life will be curtailed; robberies and destruction of property will be prevented.

Inasmuch as the Annex has now been in operation for about seven years, it would appear that a research program is in order and should be of considerable aid, relative to future institutional planning, not only in New York but in other states.

The Annex of State Training Schools for Boys.
New Hampton, N. Y.

EDITORIAL COMMENT

ANTHROPOLOGIA

The riddle of the Sphinx, as Oedipus learned long ago and far away, is easier than the riddle posed by its answer. Man is the creature that is four-legged, two-legged and three-legged; but what is man? What is his role on the universal stage and how should he play it? How does man behave; and how should man behave? And just what are we specialists in how man behaves trying to do anyway?

This is all by way of a little of the pondering we think psychiatrists should sit down and do at intervals—and this is one of the intervals. The job of psychiatry, as we conceive it, is to restore to normal relationships, normal function and normal emotionality those we generally consider to be the deranged members of the human race. And we think we ought to remind ourselves—annually or so at least—that we need to know more about the normal relationships, functioning and emotionality of members of the human race.

This is not a point on which to be dogmatic, but we sometimes wonder if we do not know nearly as much about the normal needs and normal functioning of the great apes as we have been able to learn—through the highly subjective process of self-observation—about ourselves. (Not to mention, of course, the bees and the birds and the flowers.)

From time out of mind, of course, we have had a rough rule of thumb for judging mental abnormality. We know it as the standard of social acceptability. A person whose behavior is both irrational and annoying is not socially acceptable; and we ordinarily judge such a person to be mentally abnormal. Such a person would be judged abnormal by any society at any time in any place.

When Abu Al-Hassan was tricked by Haroun Al-Rashid's practical joking into thinking that he himself was Commander of the Faithful, his neighbors, believing him hallucinated, had him dragged to the madhouse, where he was thrown into an iron cage and beaten until his "delusions" left him—the standard psychiatric treatment of a comparatively enlightened society of the eighth century of our era. Abu had become socially unacceptable; he

was isolated and treated until he became socially acceptable again. But Haroun's peculiar sense of humor was socially acceptable; so were his notable and persisting attacks of severe mental depression; so was his paranoid turning on, and execution of, his great grand vizar, Giafar, and all but one member of Giafar's family, the numerous, famous, and accomplished family of the Barmecides. The citizenry might wonder, deplore, or even mourn; but one generally does not find caliphs socially unacceptable. A caliph's annoying irrationality may be generally accepted as normal. Haroun is not recorded in history or legend as "insane."

So the standard of social acceptability—though maintained in all times and places—differs from time to time, place to place, and even from personality to personality. There have been other societies, and those not the most advanced by present standards, where even a monarch's conduct could be socially unacceptable. George III was once sent back to his restraining chair, straight waistcoat and course of blistering for the indecorum of expressing a broad double meaning in talking to a lady of the court.

Except in the remaining despotisms (societies like Haroun's own), Al-Rashid's conduct would be accepted by society or considered normal nowhere in the world today. And poor George's mild exhibition of hypomania would be socially acceptable in many strata of modern life. Far less decorous remarks are current, for example, in the entertainment world, from night club floor show to video; and one suspects that his feeble royal witticism would arouse no emotion but transitory pity in today's café society.

By what standard does the psychiatrist measure, in concluding that both Haroun and George were abnormal? By what rule would he judge—as any modern psychiatrist would—that Haroun's practical jokes were psychopathic if not criminotic (in Arthur Foxe's terminology), that his depressions would have warranted institutionalization in a Bagdad civil state hospital; and his slaughter of the innocent Bermecides, confinement to some medieval Matteawan as "dangerously insane"? Or what rationalization would the modern specialist find for agreement—and he certainly would agree—with his predecessors who found King George's sudden impropriety evidence of a relapse? In the first instance, we wonder if we would not be judging by modern standards of social acceptability; in the second, we, of course, have the same information that was available to the 18th century medical men in the form of the

king's case history; but we must be applying, too, not the standards of our day—which would find George, at the most, simply guilty of bad taste and worse manners—but the standards of social acceptability of his own court, standards set by the king himself in his more normal periods. And we think there is still something else involved in this, something else than the social standard, something more rational, more nearly approaching the objective. When we list what we consider the common symptoms of psychosis, most are manifestations that could have been recognized at any place or any time. Their contemporaries had no more doubt than we of the derangements of Commodus or Ivan the Terrible, or of the terminal madness of the great Alexander.

A person is psychotic, we agree generally, when, to cite some few instances, he hears voices or sees objects that are not there, when he is depressed or elated without adequate reason, when he is suspicious without grounds, or when he is grandiose without warrant—and when any or all of these attitudes cannot be influenced by reason. But these matters upon which there is general agreement are full of subjective judgments and description of doubtful validity. How do we determine that voices or objects "are not there," what is "adequate reason" for an emotional state, and what are "grounds" for suspicion and "warrant" for grandiosity? The existence of something is judged by whatever evidence is acceptable to the individual on the basis of his education and his social setting; and the reason, the grounds or the warrant for a thing must be similarly judged by individual and social standards.

This state of affairs, we not only hasten to admit but to assert and to maintain most firmly, hampers the clinical practice of psychiatry little or not at all. The trained and experienced psychiatrist can arrive at a judgment of normality or abnormality with very nearly the assurance he would have if he could use one of the comparatively objective measuring devices of the engineer or the apothecary. This journal has deplored in the past glaring differences in diagnoses between state and state, institution and institution. These things are unfortunate for statistical, epidemiological and other reasons, but they are not particularly remarkable.

What is considerably more remarkable is the astonishing amount of agreement we are accustomed to find between staff meeting and staff meeting, physician and physician—and the existence of a gen-

eral consensus that the diagnostic confusion can be brought to order, not by the employment of new tools for diagnosis, but by agreement on the use of those we have. Thus, if we point to our lack of such devices as those employed by the engineer and the apothecary, we are not pointing out that we do not know where we are at—for we think we do—but are suggesting that it is very good for psychiatric specialists, once in a year or so, to stop, examine, and ponder upon the nature of the tools we have.

The instruments of psychiatry and the judgments of psychiatry are derived from psychiatrists' individual backgrounds, within their individual educational and social settings. No matter how earnestly we may endeavor to sort out for more objective use and evaluation, the elements common to psychiatric judgments in our day and to those of psychiatry's recent and remote predecessors, we still cannot eliminate material which derives from individual experience or social setting. That is, we have no instruments to determine when a person is abnormal that can be used, without reference to the social situation, or divorced from the personal element—as we could come close to doing if we could solve our problems by mathematics, for instance.

Thus, psychiatry's necessarily reversed approach—for psychiatrists who deal primarily with the abnormal must reach their definition of the normal by first defining the abnormal and then conceiving of the normal in terms of the absence of abnormality—can no more be completely separated from its social frame than can the direct approach from the general or mental hygiene point of view be divorced from its similar social frame. We offer, as a non-technical attempt at a definition of normality from the general public's point of view, the remarks of a traditional authority—an intelligent (and in this case well-informed) layman—to the effect that a normal person is one who uses his reason, isn't too tense, is not governed by emotion in emergencies, and is free from such things as delusions and hallucinations. We fail to see that this differs materially from the oft-repeated definition of a distinguished contemporary psychoanalyst, to the effect that a normal person is one who is "not too neurotic." One judgment, of course, is as subjective as the other; and in both, of course, the social element is implicit. A normal person uses his reason, isn't too tense, or is not too neurotic in the social framework.

The task of psychiatry, therefore, in restoring to normality, or that of mental hygiene in conserving normality or educating toward normality, is in large part that of adjusting to the social framework. We hesitate to mention this self-evident, commonplace, bromidic fact, but Robert Lindner, Ph.D., a well-known psychologist and psychotherapist, a gentleman whose capacities and professional attainments are respected, has just written a white-hot book, *Prescription for Rebellion,* on the subject. In it, he calls for scientific rebellion on the grounds that the ideal of adjustment is being invoked and encouraged with the intent of perpetuating a less-than-Utopian *status quo.* We may consider the sort of revolt he has in mind a uselessly destructive performance, and the intent to perpetuate the *status quo* something less of an intent than he seems to hold; but we could join him, nevertheless, in examining the situation that stirs him to revolution. We think the business of what we are adjusting to and why might call for more consideration than we seem to have been giving it. We not only need, if there is any way to work toward them, standards for judging normality that are less subjective and less intimately knit with our social system than those we must—in default of better—now use; but we also need to examine, at least occasionally, whether present standards are serving a socially desirable and emotionally healthful purpose.

What does this business of "adjusting" a person satisfactorily mean to those in the field of psychiatry? It means, of course, therapeutic success, the discharging of a patient from an institution, the termination of a neurotic's office psychotherapy, the sending of a problem child back to do satisfactory work in school. The "adjusted" patient may have social and emotional handicaps; he may have disease residues which force him to compromise with his voices or compel him to engage in irrational, psychoneurotic rituals, he may be frustrated and unhappy; but at least he is functioning with lessened burden to himself, his family and others. His disability in general is lessened. Frequently, he is as good, or almost as good, as new; he often is entirely without intellectual, whatever his emotional, handicaps. And if we cannot precisely jubilate over all results of our treatment; we do not expect the surgeon to save all damaged limbs either. But social adjustment means something far short of achieving perfection (whatever that is) in a personality. And we think we should ask ourselves once

in a while if it really means what normality ought to mean. The normal person, as we now generally employ the term, is a well-adjusted person, or a person who is as happy as may be under his circumstances; even though he is not enjoying the fullest use or making the most profitable use of his emotional and intellectual capacities. He is, first and most important, a person who is accepted without too much grief by his fellows and his society; and we wonder sometimes if this is the best target we can find to aim at, or if something more ambitious would not serve us, our patients and our society better.

We are not undertaking psychiatric treatments merely to exhibit the results *in vacuo*. Our results are exhibited, not only in something that is far from a vacuum, but in an environment that practically all of us would concede does not represent the best of all possible worlds. We think that we would do well to examine and re-examine frequently the question of what sort of adjustment we should seek in a less than ideally perfect social setting. For we do not believe, and we do not think many scientific men believe, that we ought to be satisfied with the world and its institutions as they are. Our nations and all their institutions are under the Damoclean threat of a sword forged in the terrible process of nuclear fusion from the power that maintains our own and billions of uncounted other suns. We have civil and international warfare; our cities are afflicted with cheats, thieves, murderers; too many of our own and the rest of the world's peoples are lacking in what we would consider desirable in the way of food, clothing, shelter, and economic, social and intellectual opportunity. We do not think the "adjustment," for which we work and ought to work, should imply satisfaction with that. But we do think there are people here and there who like this or that feature of things as they are and who would like to see psychiatric "adjustment" employed, with many other things, to make men satisfied with less than their aspirations and so preserve the world from changing. And this is no more than to chronicle the fact that man—despite his vast capacities for social and familial co-operation, for love and altruism—possesses selfish and predatory instincts, and that some men find those instincts well satisfied with human affairs in the chaotic state in which they are.

Whether society is neurotic may be a question for the semanticists, not the psychiatrists. We believe there is general

agreement that it is not a Utopia in anybody's terms. But we believe we shall also find agreement in the statement that the conscious aim and the manifest endeavor of man are to change, to improve, to further human progress. And, be it noted, we are not discussing probable results, or the desirability of this or that, but aims and endeavors. We think there are comparatively few persons, of whatever political, social or religious persuasion, this side of the Iron Curtain who do not share in aims to better man's lot. It is a cornerstone of faith in science that the advance of knowledge and its applications in technological improvement will continue—and that man and his institutions will profit in consequence. But the advance of knowledge and the application of new techniques mean change in, and imply less than satisfaction with, things as they are.

We think those engaged in mental hygiene should consider the possibility of overstressing the business of adjustment without stressing sufficiently what it is we are adjusting or to what we are adjusting it. We think, and we do not blame anybody for it, that there may be considerable confusion in the general mind and in the minds of some practitioners between emotional adjustment and intellectual. We think we might do well to stress the fact that what we seek through mental hygiene is emotional adjustment, not the intellectual variety. We may adjust emotionally to many things, accept them without too much grief or without mental aberration, and still abhor them intellectually. It is not our business to adjust people intellectually, we do not try to adjust people intellectually, and we think if intellectual adjustment could be achieved it might spell the end of progress for humanity. Scientific curiosity, healthy skepticism, even good citizenship, depend on intellectual non-conformity, as well as on other factors. We are all for the business of adjusting mankind emotionally but think intellectual adjustment might well be disastrous.

Suppose one lives, for instance, in the vicinity of an unpleasant and unhealthful slum area. If one is emotionally maladjusted, he may rant about it, smash windows, kick the cat, burn the buildings, throw stones at landlords, or incite a series of riots. If he is emotionally adjusted, he will be disturbed by his slum neighborhood but will retain control of his actions. What he does then will depend on his degree of intellectual adjustment to the situation and his intellectual acceptance of the situation. If he is intellectually

maladjusted to poverty and suffering—and we hope all good citizens are— he will support every official and unofficial movement and organization which can be induced to take an interest in clearing up the area. We take it that intellectual adjustment to such a situation would imply acceptance of poverty, suffering and slum conditions in a world that it is foolish for the individual to attempt to better—if, indeed, it is not the best of all worlds possible. Similarly, emotional reaction to stuffed ballot boxes and stolen elections might involve anything from minor rioting to a call for Judge Lynch. On the other hand, intellectual refusal to accept such a situation might take many forms, from protest meetings to public prosecution. The form action takes is less important than the fact that it is emotional in one case and intellectual in the other.

We think we should perhaps make it plainer than we have done before that what we are seeking to do in both psychiatry and mental hygiene is to adjust man better emotionally to bear his lot—not reconcile him intellectually to conditions he thinks he can improve. Our aim is to reduce suffering, not set limits to thinking. It is an aim that has been clearly stated, over and over again, and one which psychiatrists and social scientists of all schools should be able to accept. Freud once expressed it as an effort to bring it about that where id is, ego shall be. It can be phrased in other terms as less determination of human conduct by feeling, and more determination by (the distinctively human process of) thinking. We think if we could make this aim plainer in our practice and our preaching, there would not only be lessened danger of perversion of our efforts, but that there would be less misapprehension of the direction of our trend by such serious observers as Dr. Lindner.

And this, by dissertation about this and that in the field of psychiatric practice and theory, may suggest, at length, another standard than the strictly social which we may apply to our question of what is normality. It is the standard of intellect versus emotion (ego versus id), and as standards go it is by no means as exact as a mathematical formula, or even as a measurement in nuclear physics. But it is something that, we think, the human mind in its social setting, can measure more objectively than most matters in that same setting. By that standard, we would consider a person normal and well-adjusted who accepted highly unpleasant facts of life in his surroundings without emotional distress leading to inca-

pacity to maintain himself, moods dangerous to himself or other people, or conduct necessitating institutionalization. But we would not consider him normal or well-adjusted if he accepted, without thought or intellectual effort to do something about it, a highly unpleasant personal or social situation.

Most of us reasonably adjusted (that is, non-hospitalized) people do not go into depressions or catatonic stupors or screaming fits in fear of the hydrogen bomb; but few of us are intellectually adjusted to the situation—which would be a sign of subnormal mentality; and most of us are intensely interested in seeing that the people we have chosen to govern us take all possible rational steps to do something about it. Or on the individual scale, an employee who is well-adjusted emotionally does not hurl a typewriter at however hated an employer; instead, if his mentality is normal, he tries to get another job.

We think that this imaginary picture of a normal person as one who can accept vicissitudes emotionally, but question and strive against them, fight intellectually, is worth consideration both in our role as medical specialists and in the wider role of social scientists promoting general mental health. We do not suggest it as a completely satisfactory definition, or even as a reasonably good one; but the business of considering it might well lead to something more objective. And we are fully aware, among the obstacles to practical use, of the vast and almost insuperable obstacle of determining when something is emotional and when it is intellectual. We do not object, of course, to the coincidence of emotionality and intellectuality; when pleasure and intellect dictate the same course, we may truly have found a step on the road to Utopia. But we think we should make it plain among ourselves and in our public pronouncements that we are trying to do one thing in the realm of the emotions and quite another in the territory ruled by the intellect. We think, if we could make a start with these considerations in mind, we might eventually have a far more satisfactory formulation of what it is all about and of what we are trying to do about it than we have at present. And we think that, in the meantime, we might not only get a clearer view in our own minds of what it is all about, but might direct our activities, particularly in the mental hygiene field, far more intelligently.

BOOK REVIEWS

Progress in Clinical Psychology. Volume I (Section 1) and Volume I (Section 2). Daniel Brower and Lawrence E. Abt, editors. Section 1, 328 pages; Section 2, 564 pages. Cloth. Grune & Stratton. New York. 1952. Price, Section 1, $5.75; Section 2, $5.00.

This book is Section I of a two-section survey, the purpose of which is "to provide as complete a coverage as possible of the past six years in clinical psychology and to point up, in the process, as many stimuli as possible to further thinking and research." While Section II deals with developmental processes and approaches to the field, Section I is concerned primarily with diagnostic and therapeutic procedures. It is divided into three parts. Part I is an introductory chapter by co-editor Lawrence Abt on "The Emergence of Clinical Psychology." Part II consists of chapters on diagnostic and evaluative procedures by experts in each area.

Most of the chapters in Part II deal with the various projective techniques although there are also chapters on intelligence and aptitude tests, as well as a chapter on personal documents. The projective tests specifically considered, with a chapter devoted to each one, are the Rorschach; TAT; House, Tree, Person; Gestalt Functions; Bender-Gestalt Mosaic; and World tests; Sentence Completion; Word Association; and the Szondi Test. Part III consists of reviews of recent progress in the various fields of psychotherapy including group therapy and play techniques.

Whereas the first section of this two-section survey of progress in clinical psychology in the past six years—that is, since World War II—deals with progress in diagnostic and therapeutic techniques, Section 2 deals with the various areas with which clinical psychology is concerned. The first part of Section 2 takes up developmental processes, with individual sections on infancy, early childhood, the latency period, adolescence and gerontology. The second part is concerned with the application of clinical psychology to special areas, such as the more traditional areas of educational psychology, vocational counseling and mental deficiency; to relatively more recent areas such as accessment, rehabilitation, military and other governmental programs, and addiction. The third part of the book is concerned with "Approaches to Clinical Psychology" such as psychosurgery, anthropology, and statistical methods. The book closes with a final chapter on "Clinical Psychology as a Profession."

Each chapter is written by a different authority, and, while they vary in length as well as depth of analysis, Section 2 as a whole is recommended as an up-to-date survey of the research in the rapidly expanding field of clinical psychology. Especially useful are the extensive references to recent studies given at the end of each chapter.

The Cerebral Cortex of Man. A Clinical Study of Localization of Function. By WILDER PENFIELD, C. M. G., M. D. (Johns Hopkins), B.Sc., and D.Sc. (Oxon.), Hon. F. R. C. S. (London), F. R. S., professor of neurology and neurosurgery, McGill University; director, Montreal Neurological Institute; and THEODORE RASMUSSEN, M. D., professor of neurological surgery, University of Chicago. XV and 248 pages, including introduction to the 1947 Lane Medical Lectures, preface, bibliography, case index, general index and 121 figures, photographs and drawings. Cloth. Macmillan. New York. 1950. Price $6.50.

This monograph on *The Cerebral Cortex of Man* is a magnificent and classical example of scientific research, of ceaseless endeavor of great explorer-physicians and of superior skill. Its presentation, its clearness, instructiveness and arrangement are above any criticism. It follows mainly the work of Jackson and Broca, Cushing, O. Foerster and the Vogts, Brodman and Sherrington. But it goes far beyond their explorations, adding immense new knowledge of the localization of cortical functions.

It must be studied in detail. It is an indispensable fundamental textbook for physiologists and neuroanatomists as well as for neurologists, psychiatrists and neurosurgeons.

Here Today. By JOHN COATES. 264 pages. Cloth. Macmillan. New York. 1950. Price $2.75.

A third-rate burlesque is dressed up here as first-class satire. The humor is thin and weary: a British business man informs his partner that he travels in time, one of the stations being Jane Austen. The sane partner consults a psychiatrist who mistakes him for the sick one. This gives the author the possibility of ridiculing the whole profession: "I carry on my business" (thinks the sane partner) "and make a modest profit on the assumption that two and two equal four. In Middle-Europe two and two and an erotic nurse-maid in your childhood can equal anything." With modern psychiatry relegated to the realm of foreign fancies, British spelling, wives, unpunctuality, and other "national" characteristics are subjected to irony on the identical sub-humorous level. The remaining parts of the "novel" are just as inane.

The Witching Night. By C. S. CODY. 255 pages. Cloth. World. New York. 1952. Price $2.75.

The author of this book apparently has a very good knowledge of medieval witchcraft lore. His material concerning the Black Mass and related subjects is authentic. This authenticity, however, is the only claim the book has to being better than mediocre. This is too bad, as the author has writing talent to suggest that he might some day rise above the level of the "hacks" who comprise the vast majority of fantasy writers.

The Tree Test. By CHARLES KOCH. 87 pages. Cloth. Printed by Hans Huber, Bern. Distributors in the United States, Grune & Stratton. New York. 1952. Price $7.00.

Clinical psychologists are becoming increasingly interested in projection of personality through drawing techniques. One popular form is Machover's Draw-a-Person Test; Buck carried this procedure a step further, by utilizing separate projections of a house, a tree, and a person—this test is known as the HTP technique. Clinicians, of course, realize that the basic assumptions of these techniques have not been experimentally verified. Nevertheless, for practical purposes, "they work."

Koch has now written a further elaboration of the projection method, and has called it The Tree Test. The format is divided into: I, Introduction and examples; II, Tables for the Tree Test. In Part I, Koch discusses theoretical formulations, and gives analyses of trees drawn by five persons; in Part II he compiles tables for the Tree Test, giving interpretations for drawing variations, e. g.: When the base of the trunk is "broad on the left," it can mean "inhibition, initial inhibition, brake, relating to the past, 'sticking,' failure to free oneself from something, bound to Mother."

Koch's method differs from Buck's; he asks the subjects to draw "a fruit tree" rather than "a tree"; he does not record the subject's "sequence of detailing"; there is no "good" or "flaw score" consideration; he conducts no "post-drawing-inquiry;" and he does not attempt classification. Both methods, however, emphasize drawing as a projective technique and the need for further standardization. The Tree Test is recommended for the attention of progressive clinicians.

Psychiatric Sections in General Hospitals. By PAUL HAUN, M. D. 73 pages with index. Cloth. Country Life Press. Garden City, N. Y. 1950. Price $4.00.

The author of this book is eminently qualified to write about this field. He is chief of the hospital construction unit of the VA Psychiatry and Neurology Division. The material presented is esoteric in a sense, but should be carefully studied and assessed by hospital administrators, hospital boards, local psychiatrists, and medical men, particularly in communities away from metropolitan areas, who are considering plans for much-needed psychiatric care in general hospitals. These psychiatric units, however small, are a great need in most smaller cities, where psychiatrists in private practice are constantly faced with inadequate or no facilities for hospitalizing the disturbed patient, other than state hospital commitment or private sanatoria.

Detailed construction plans are set forth, with sound treatment rationale, and future needs of the unit are anticipated. Hospital architects will be called upon frequently to deal with the problems presented here, as the demand for these units increases.

Gestalt Therapy. Excitement and Growth in the Human Personality. By FREDERICK S. PERLS, M. D., Ph.D.; RALPH F. HEFFERLINE, Ph.D.; and PAUL GOODMAN, Ph.D. 466 pages. Cloth. Julian Press. New York. 1951. Price $6.50.

According to the introductory chapters, this book began as a manuscript written by Dr. Perls and developed by the other co-authors. They planned "to develop a theory and method that would extend the limits and applicability of psychotherapy," and this they planned to do through a better understanding of Gestalt psychology. They state that ". . . to understand the book he [the reader] must have the 'Gestaltist' mentality. . . ."

The book is divided into two volumes, the first volume covering a definition and an explanation of the basic principles of Gestalt psychology and then following with a long series of psychological experimentations in which the reader places himself and follows the suggestions presented by the authors. These experiments are extremely interesting. They present a tremendous number of ideas which the psychotherapist can utilize.

Volume Two presents the authors' considerations of the "theory and practice of Gestalt-therapy, the science and technique of figure/background forming in the organism/environment field. . . ." This volume presents many ideas but often many confusing ideas. No doubt, those who are especially well acquainted with Gestalt psychology will understand every meaning but others will remain confused. This reviewer, who sought earnestly to read and to follow the theme logically, was confused. In other words, the authors seem to have many good ideas but they are not well put togther. They were hard for the reviewer to accept—not necessarily because they were wrong—but because they were not understood.

Bull Fighter from Brooklyn. By SIDNEY FRANKLIN. 245 pages. Cloth. Prentice-Hall. New York. 1952. Price $3.75.

Sidney Franklin's autobiography should offer hopes of giving insight into the emotional background of a bull fighter, but this is not accomplished. The material, while very personal in spots, gives no more than vague clues regarding the author's inner motivations. The book, as a popular autobiography, however, makes interesting reading. It is the emphasis upon the small details of the profession that give such an air of authenticity—the behind-the-scenes rivalries and preparations.

Will of Iron. By ISIDORE ROSEN. 284 pages. Cloth. Crown Publishers. New York. 1950. Price $3.00.

This is a rather naïve story of a Jewish matriarch in Brooklyn's Brownsville during the 20's. The author seems to be of the erroneous opinion that description alone is a suitable substitute for psychological insight. None of the characters is endowed with motivations beyond the obvious conscious ones.

Understanding Children's Play. By RUTH E. HARTLEY, LAWRENCE K. FRANK and ROBERT M. GOLDENSON. 372 pages. Cloth. Columbia University Press. New York. 1952. Price $3.50.

This book presents observations on approximately 180 children from two to six years of age in various play situations. The authors hope that the text will be "(1) useful in the training of nursery play and elementary school teachers and kindergartners; (2) enable directors and teachers to develop the full potentialities of toys, games, creative materials, and play activities for fostering the growth of children into healthy personalities; and (3) interest . . . parents in providing suitable play materials for their children, and especially for children, who, because of some handicap or chronic illness, might otherwise be deprived of the play experiences they need for emotional expression and maturation."

There are excellent chapters dealing with dramatic play, block play, water play, use of graphic material, finger painting, and music and rhythm. Throughout the book, recordings of children at play are presented. The appendix lists helpful suggestions for observing and interepreting young children's play.

Parents, social workers, psychologists, teachers and all others interested in understanding and interpreting the play of children will find this book interesting and helpful.

The Monk. By MATTHEW G. LEWIS. 445 pages. Cloth. Grove Press. New York. 1952. Price $4.75.

The true "Gothic Novel" in English literature came, passed, and has been all but forgotten. The stalking ghosts, bloody daggers, and eerie castles lost interest when they lost their novelty. One of the best of this species was *The Monk* which is now, for almost the first time, available in unexpurgated form. Lewis, at times, shows good characterizations, particularly when dealing with the monk, Ambrosio, but this does not make the book psychological. One may read the book, perhaps enjoy it, but any attempt to "read psychology into it" is doomed to failure. The author was never, despite his attempts, able fully to surmount the ideas of his age or the limitations of the novel form chosen.

The Uses of the Past. By HERBERT J. MULLER. xi and 394 pages. Cloth. Oxford University Press. New York. 1952. Price $5.50.

Comparative history offers many pitfalls for the author, and this book does not avoid all of them. A lack of cohesiveness is apparent at times, and difficulty will be encountered by the reader in extracting the central theme. Social and religious history are the main concerns of this book, and the author shows himself to be a strong opponent of the authoritarian idea in all fields. There is some effective sniping at Toynbee and his twin ideas of "cycles" and of the bolstering effect of religion upon a civilization.

Understanding Your Child. By JAMES L. HYMES, Jr. xii and 188 pages. Cloth. Prentice-Hall. New York. 1952. Price $2.95.

Amusingly illustrated by H. W. Doremus, *Understanding Your Child,* by James L. Hymes, Jr., is an informal, human, mirth-provoking book on child psychology that is at once good reading and instructive. The book makes sense; it is intelligent in outlook and in purpose; it is sound; it is to be recommended not only for its viewpoints but for the accompanying illustrations and for its philosophy of child-rearing. In fact, it is an indispensable piece of literature to be recommended by pediatricians and child specialists for parents with children of all ages.

Dr. Hymes obviously knows children from all angles of their development; and in his *Understanding Your Child* he points the way to a flexible, understanding and sympathetic interpretation of the actions and doings, the whims and desires, and the general behavior patterns of children. The author would have the readers of his book come in time to deal with youngsters on a basis of true love and respect for them as individual human beings. On such a sound premise, then, does Dr. Hymes feel our most wholesome way of life can be founded and preserved. The author is certainly realistic, but he is sound in an orthodox way, too. He is not smug in his dealings with parents; he would have them take into account the day-by-day crises that inevitably arise, and he gives constructive ideas on how to handle parental problems. If, from the content of this book, one is to single out the particularly worth while, one should note that it demonstrates that family security results from a happy, well-adjusted personality in each of the children, which, in totality, amounts to successful living as a family-unit.

Cast a Cold Eye. By MARY MCCARTHY. 212 pages. Cloth. Harcourt, Brace. New York. 1950. Price $2.75.

These seven short stories, written with bitter-sarcastic wit, show a peculiar discrepancy: The author understands *intellectually* only the aggressive part of human "nature," whereas the masochistic sector is misunderstood. Sometimes, obviously without her knowledge, traces of unconscious understanding of the latter creep in, to be promptly—intellectually—misconstrued.

Philosophy and Psychoanalysis. By JOHN WISDOM. 282 pages. Cloth. Philosophical Library. New York. 1953. Price $5.75.

Despite the title, this book deals very little with psychoanalysis; in fact, only in the last of 15 articles is the subject more than touched on. The major effort of the book deals with the pinpointing of philosophical terms and ideas. This, while it may be necessary to the student, does not make for interesting reading.

Of God, The Devil and the Jews. By DAGOBERT D. RUNES. 186 pages. Cloth. Philosophical Library. New York. 1952. Price $3.00.

Of God, The Devil and the Jews, by Dr. Dagobert D. Runes, is a book of sound convictions, profound thoughts, and strong views on the general theme of ethics in our contemporary world. The title is strange, to be sure; but a close reading of the treatise shows it to be appropriate. The author obviously possesses a deep sense of moral passion; he has thought deeply and with sensitivity about the western world and its machinations; and in his good sense of religiosity, Dr. Runes logically considers varied factors in present day affairs.

Dagobert Runes is a moralist as well as a literary man of consequence. This recent book is a kind of anthology of essays with a connecting theme, related to God, to Man, and to the aspects of life related to both. It is a challenging book, rather staunch in its viewpoints, and reveals the wealth of the author's reading and thinking and experiential knowledge. The individual chapters are essentially essays that bear intellectual proximity to each other. Witness, for example: "Christ Stopped at Georgia," "Amor Apostolorum," "The Crime of Punishment," "Convert Jews and Convex Christmas," and "Sin, Sex and Sanity." The scope is broad, and the argument is disturbing, yet stunningly clear. The author pleads, by intimation, for the enhancement of our cultural heritage through the psychology of true religion, through human logic that is at once flexible and humane, and a moralism that is poignant and intelligent.

A Moon for the Misbegotten. By EUGENE O'NEILL. 177 pages. Cloth. Random House. New York. 1952. Price $3.00.

This unproduced play has been extensively reviewed as another instance of O'Neill's re-casting a classic Greek dramatic theme into a modern setting. The setting is in its own peculiar way almost as sordid as that of *Tobacco Road;* the theme is frustration and futility. It is faithful study of human behavior and human beings, like most of O'Neill's plays. But the narrative is slender and the event pitiful. It is far from achieving the heights of classic tragedy which O'Neill has reached in the past.

It's Mine! By ELLY MCKEAN. With a Foreword by Lawrence K. Frank. 36 pages with illustrative photographs. Cardboard. Vanguard. New York. 1951. Price $2.00.

This attractive little picture book on an important problem of child guidance is a well-conceived method of introduction and instruction for parents and teachers in the ways of teaching children to respect the property rights of others and to adjust to life in society. A short introduction by L. K. Frank gives some psychological fundamentals of child behavior and maturation. The book can be recommended to all concerned, and it may find a worthwhile place in the waiting rooms of pediatricians.

Alcohol, Culture, and Society. By C. H. PATRICK. xv and 176 pages. Cloth. Duke University Press. Durham, N. C. 1952. Price $3.00.

C. H. Patrick is professor of sociology at Wake Forest College. His book gives us another view of the elephantine problems of the fourth most common disease. Certainly, all people interested in the problem of alcoholism must realize that no single method of treatment or control has been effective in the past. Without epidemiological and genetic studies, no picture of a public health problem can be complete.

Professor Patrick discusses essentially the socio-psychic etiologies of alcoholism by reviewing what is recorded or known of social and cultural traditions and customs. His conclusion that this background predisposes the individual to, or may be the exciting cause of, alcoholism is well founded. In a way, he shows that the use of alcohol may lead to alcoholism (abuse). Thus his chapter on "Why Mankind Uses Alcoholic Beverages" is of great significance. His other chapters showing the effect of alcohol on the individual and society lead well into the last chapter "Toward Social Control." Although most of the subject matter is on the social level, some is on that of the individual.

There are 10 tables, an eight-page bibliography, and a 10-page index. The text is presented in logical sequence and is easy to read. One gets the impression of objective observation and scientific analysis by a sociologist. It is recommended reading.

Interpersonal Relations in Nursing. By HILDEGARD E. PEPLAU, R. N. xxii and 330 pages. Cloth. Putnam. New York. 1952. Price $5.00.

Miss Peplau has applied psychoanalytic principles to the practice of nursing, and has developed the interpersonal relationships found in the field along these lines. There is a question of the value, in any practical sense, to the average nurse of the material to be found here, as the book presupposes a strong basic knowledge of psychiatry. Only by close study could the non-analytically-trained person avoid confusion. As a text for nursing instructors, it might serve a greater purpose, though even here its value is questionable. Being herself a student at the William Alanson White Institute, it is not surprising that the thinking of Sullivan and his school have influenced the author's work.

Rose's Last Summer. By MARGARET MILLAR. 245 pages. Cloth. Random House. New York. 1952. Price $2.50.

Margaret Millar, always a master of the psychological mystery novel, has kept up her usual high standard in this one. Not only is this a book of suspense and mystery, but one of riotous comedy as well, one of the best pieces of writing this author has given us. It is a must for the discriminating mystery fan. It is also a sound and—which is most unusual—amusing picture of psychopathy.

Current Trends in Psychological Theory. By W. DENNIS, R. LEEPER, H. F. HARLOW, J. J. GIBSON, D. KRECH, D. McK. RIOCH, W. S. McCULLOCH, and H. FEIGL. 213 pages. Cloth. University of Pittsburgh Press. Pittsburgh. 1951. Price $4.20.

Eight lectures under the auspices of the department of psychology in The College of the University of Pittsburgh delivered in 1951 in the Stephen Collins Foster Memorial series are published under the title *Current Trends in Psychological Theory*. Each of the contributors has presented a viewpoint in the little volume; and the individual papers are collected in one binding in a sort of anthology version without sufficient editing to make for full consistency. Yet, the book in itself is not only interesting but informative. The title, however, is far too broad and too sweeping in compass for the book's actual contents.

Wayne Dennis contributes the opening essay on "Developmental Theories"; Robert Leeper handles well "Theories of Personality"; H. F. Harlow writes with erudition but without spark on "Learning Theories"; J. J. Gibson contributes an essay on "Theories of Perception," which summarizes the facts well; David Krech deals with "Cognition and Motivation in Psychological Theory," and has a message of psychological significance; "Theories of Psychotherapy" by David McK. Rioch is written with experiential discernment and insight; W. S. McCulloch's "Brain and Behavior" is basic in its approach and well worth reading, and Herbert Feigl's "Principles and Problems of Theory Construction in Psychology" gives a philosophic grasp to the science of psychology. The theme of the book may be summarized in Leeper's words: ". . . the chief value of psychology lies in the fact that it has been creating tangibility for those factors which can be proved to be significant. . . ."

How to Help an Alcoholic. By CLIFFORD J. EARLE. 96 pages. Cloth. Westminster Press. Philadelphia. 1952. Price $1.50.

Dr. Earle has written a very short but practical book for the layman's understanding of the alcoholic.

The great number of problem drinkers—one out of every 30 or 40 persons—makes for rather close contact for most of us. Although there is very little discussion of the unconscious needs of the alcoholic, the chapter on "What Not to Do" makes some allusions to those needs which most well-meaning families and friends do not supply.

Dr. Earle discusses the A. A. (Alcoholics Anonymous) steps and traditions, with a chapter on the help of religion. The author is a graduate of the McCormick Theological Seminary of Chicago. He shows good qualifications in differentiating well-meaning ministers from those who are well-understanding, in his chapter on "Strength in Religion." Part II, of 16 pages, gives some very practical "Help for Alcoholics." The book is highly recommended to anyone in close association with an alcoholic.

Faces in the Crowd. Individual Studies in Character and Politics. By DAVID RIESMAN. In collaboration with Nathan Glazer. xii and 751 pages. Cloth. Yale University Press. New Haven. 1952. Price $5.00.

The author of *Faces in the Crowd, Individual Studies in Character and Politics* is professor of social science at the University of Chicago; and in this searching study, David Riesman again produces a brilliant and stimulating argument in the area of social relations. Professor Riesman is the author of *The Lonely Crowd,* as readers will remember; and, with this volume for review, it is quite impossible to do justice to the breadth and richness of Mr. Riesman's material. The author's mind and pen, with the collaboration of Nathan Glazer, are vigorously provocative.

Professor Riesman is as much a brilliant psychologist as he is the sound social scientist. He combines lucidly the dialogue of the interviewees quoted in this book with his penetrating analyses. The main emphasis in *Faces in the Crowd* is on individuals, in fact. The major bulk of this volume consists of 20 or so portraits or "faces" of individuals, based on interview materials. The preoccupation of the author is with character structure, with politics, and with the relation between them. The volume is divided into two major sections: Part I provides an account of the methods used in assembling the portraits and of the typologies used in analyzing them; Part II contains the portraits, grouped very roughly in terms of the character types they illustrate.

Faces in the Crowd is the work of a man who knows his field beyond a measure of doubt. While he at times deals theoretically with many ramparts of the areas and disciplines of the social sciences, Mr. Riesman has made a highly successful attempt to set forth a new basis for political concern in the modern world.

Design for a Brain. By W. ROSS ASHBY. 254 pages. Cloth. John Wiley & Sons. New York. 1952. Price $6.00.

The author, director of research at Barnwood House, Gloucester, attempts to explain "the origin of the nervous system's unique ability to produce adaptive behaviour." He stipulates that the inner machine must "behave at once mechanistically and adaptively." He also finds the tool he is seeking in the "principle of ultrastability": "An ultrastable system acts selectively toward the fields of the main variables, rejecting those that lead the representative point to a critical state but retaining those that do not" (p. 91). All this is explained with many mathematical deductions, beyond the comprehension of the physician. What the physician can grasp is the omission of unconscious factors. The principle of ultrastability seems to leave no room for the unconscious in the clinical sense; one wonders why a "design for a brain" should have been so incomplete. Whether the book is written for physicians or electronic engineers is unclarified.

Trial of William Palmer. Eric R. Watson, editor. 348 pages. Cloth. William Hodge and Company, Ltd. London, Edinburgh, Glasgow. British Book Centre, Inc. New York. 1952. Price $3.25.

Trial of Alfred Arthur Rouse. Helena Normanton, editor. 316 pages. Cloth. William Hodge and Company, Ltd. London, Edinburgh, Glasgow. British Book Centre, Inc. New York. 1952. Price $3.25.

William Palmer is quite possibly the most notorious poisoner in modern medico-legal history. He was tried and hanged for a friend's death almost a century ago. "Holy Willie" Palmer, as one notable student of crime has called him, was a medical man of horse-racing interests and church-going habit. Palmer seems to have poisoned as casually as he ate or drank. He was convicted of a single murder after a long and sensational trial, but there were two other murder indictments against him at the time for the deaths of his wife and of his brother. His mother-in-law, an illegitimate child, a house guest and four of Palmer's five legitimate children died under circumstances which were not unsuspicious. Palmer's medical practice had practically disappeared; his financial circumstances were precarious and his surface motive for murder seems to have been chiefly pecuniary. His trial was the first on record for poisoning by strychnia, and so made both medical and legal history. The editor of this volume notes that there has always been "a certain amount of doubt and mystery about the trial." He sees no doubt as to Palmer's moral guilt, but some question as to the medical and legal evidence. He observed that there is "available evidence" of some mental abnormality in Palmer's case—which seems a vast understatement—but adds, "It may not amount to insanity." This volume, as the record of a celebrated and precedent-setting trial, should be of interest to everybody concerned with medico-legal questions.

The trial of Alfred Arthur Rouse is of interest chiefly to students of psychopathic personality. Rouse murdered a stranger and burned the man in his car, apparently hoping that the body would be mistaken for his own, and that he thus could be free of debt and of an astonishing number of inconvenient young women. His crime was peculiarly cold-blooded and his trial of no particular medical interest. As a personality, however, Rouse may be worth some attention. The editor quotes, with approval, a feeling "that there was 'good in Arthur,' to use his wife's last commentary." The editor seems to feel that in a sense he was a psychiatric casualty of World War I in which he suffered a head wound.

Alice in Motherland. By CAROLYN BULLIS BLISH. 63 pages. The Delaware State Society for Mental Hygiene. Wilmington, Del. 1950. Price $1.00.

This is a popular introduction to motherhood and fatherhood, presented in the form of a modified fairy tale: Alice is now grown up, is pregnant, and is visited by a lecturing duo of babies—Sunshine and Gloomy.

The Adolescent and His World. By IRENE M. JOSSELYN, M. D. 124 pages. Paper. Family Service Association of America. New York. 1952. Price $1.75.

Dr. Irene M. Josselyn, a member of the staff of the Institute for Psychoanalysis in Chicago, is the author of a succinct book on *The Adolescent and His World,* in which are discussed in logical and informative style and format the physical aspects of adolescence, psychological growth patterns, the social pressures and social adaptation factors, psychosexual conflicts, psychiatric treatment of the adolescent, and sex education and sexual behavior as regards the adolescent. This volume is designed primarily for social workers and other professional persons who carry responsibility for helping to improve the interpersonal relationships of parents and children and who, through direct contact with adolescents, offer personal guidance and help in social planning. A bibliography is appended as an aid to further study of the subject.

In *The Adolescent and His World,* Dr. Josselyn analyzes well the gestalt of adolescence, psychologically and psychiatrically. To the author, adolescence encompasses an extensive period of accelerated physical and psychological growth. Its onset can be determined by observation of physical changes; and adolescence terminates physically with the establishment of the mature body structure and the mature functioning of the glands of internal secretion, particularly those directly related to the reproductive system. It terminates psychologically with the establishment of relatively consistent patterns for dealing with the internal conflicts and the demands of reality experienced by the physically mature individual. But adolescence cannot be understood in terms of one discipline, whether that discipline be physical, psychological, sociological, or educational; it is a period of radical change in the total individual. The author establishes well her thesis: That adolescence is a stage of emotional growth that cannot be avoided if adulthood is to be attained.

Empress of Byzantium. By HELEN A. MAHLER. 376 pages. Cloth. Coward-McCann. New York. 1952. Price $4.00.

This reviewer has never run into a book quite like this before, and he hopes he never does agin. If *Little Lord Fauntleroy* were to have contained a description of a bacchanale the effect would be about the same. Various and assorted passions—sexual, homosexual and incestuous—are described in minute detail, and the author lacks the competence to make the story acceptable, even as erotica. And while a great deal of historical research has gone into this book, even some of the historical assumptions could be questioned. Books such as *Little Lord Fauntleroy* are today found to be so sweet as to be nauseating. The themes, at any rate, of this book cannot be called sweet.

The Hand in Psychological Diagnosis. By CHARLOTTE WOLFF. xv and 218 pages. Cloth. Philosophical Library. New York. 1952. Price $7.50.

In *The Hand in Psychological Diagnosis,* Dr. Charlotte Wolff, a fellow of the British Psychological Society, has issued a pioneer work on the hand as a means of psychological diagnosis. The book contains 24 informative and interesting plates, illustrative of the author's viewpoints. The contents include chapters on the hand and intelligence, the endocrine factor, the hand and temperament, the hand and personality, the method of hand-interpretation, the hand of the mental defective, and the hand in mental illness.

From the clinical aspects, Dr. Wolff's treatise is especially significant, even though the writing is not so lucid nor the thesis so dialectical as might be. Dr. Wolff has made an intelligent use of extensive studies in mental hospitals, clinics and schools in studying differences between the hands of normal and abnormal personalities. Particular emphasis has been laid in this book on the characteristics of the hand in connection with endocrine functioning, mental deficiency, and mental illness; and the first part of the volume deals with the theoretical aspect of the subject and the method of interpreting the size, shape, and digits of the hand. The second part contains experimental and clinical studies—which section, incidentally, is of particular interest, then, to psychologists and psychiatrists. Finally, diagnostic hand interpretations are compared with other diagnostic estimates to exemplify the place of the hand in diagnosis.

As indicated already, *The Hand in Psychological Diagnosis* is an experimental and pioneering effort in the area of psychological and psychiatric investigation, with much work in the field yet to be accomplished. But the viewpoint is refreshing and psychologically novel, and the study may have a considerable bearing on the psychology of tomorrow.

Psychosexual Functions in Women. By THERESE BENEDICK, M. D. 418 pages. Cloth. Ronald Press. New York. 1952. Price $10.00.

This book represents mostly a reprint of a monograph, published by the author years ago, reporting on investigations terminated in June 1939. An attempt was made to determine from the psychological material, gathered in analysis, the current phase of the sexual cycle; 152 cycles of 15 women were investigated; the vaginal-smear and basal body-temperature techniques were applied. In the present book, a few chapters are added to the older monograph, including summaries on frigidity and impotence. In particular, the latter are insufficient and antiquated, and could have been written 30 years ago.

Problems of Infancy and Childhood. Transactions of the Fourth Conference. March 6-7, 1950. Milton J. E. Senn, M. D., editor. 181 pages. Cloth. Macy Foundation. New York. 1951. Price $2.50.

Family Centered Maternity and Infant Care. (Supplement I to Problems of Infancy and Childhood.) 29 pages. Paper. Macy Foundation. New York. 1951. Price 25 cents.

Adrenal Cortex. Transactions of the Second Conference. November 16-17, 1950. Elaine P. Ralli, editor. 209 pages. Cloth. Macy Foundation. New York. 1951. Price $3.00.

Problems of Consciousness. Transactions of the Third Conference. March 10-11, 1952. Harold A. Abramson, M. D., editor. 156 pages. Cloth. Macy Foundation. New York. 1952. Price $3.25.

These conferences (three separate series), held under the sponsorship of the Josiah Macy Jr. Foundation, do much toward furthering a realization of the interrelationships between the sciences in the handling of problems in medicine and psychiatry. The books reviewed comprise only a small cross-section of the project as a whole, and if the success obtained here can be taken as representative, this reviewer can only hope the techniques employed will form a model for future approaches to study. Including members with widely different approaches to the subject, a typical conference report avoids any stereotyped pattern of thoughts, and the reader is given an approach to the problem as a whole, rather than to any one facet of it —no matter how important that one facet may be. Despite the temptations that must certainly exist under the circumstances, the participants have done remarkably well in avoiding being side-tracked from the main themes, and stick closely to the subject matter of the paper that forms the basis for each discussion. While it is true that an index is not a real necessity in this type of book, this reviewer would like to see one included—with the mass of medical information now being published, anything that aids the reader in using a book as a quick source of reference is of value.

Anxiety in Pregnancy and Childbirth. By H. Klein, H. Potter, and R. Dyk. 111 pages. Cloth. Hoeber. 1950. Price $2.75.

This is a descriptive monograph, based on observations of 27 primiparous women. It is quite comprehensive as detailed surface observation but psychological elaboration is almost completely neglected. The authors conclude: "This pilot study, although suggesting how unconscious feelings may be operating in the attitudes, fears, wishes, and behavior of the pregnant woman and at delivery, allows no further positive deductions." Further scrutiny is recommended by the authors.

The Humor of Humor. By EVAN ESAR. 286 pages including index. Cloth. Horizon Press. New York. 1952. Price $2.95.

The Humor of Humor is a discussion by a man of wide acquaintance with, and reputation in, his field. It is a survey rather than an analysis. Evan Esar takes his humor seriously. He, however, maps his territory rather than explores its geology.

This book is a classification into 16 general types with numerous excellent illustrative stories and outlines of the mechanisms involved. (Gallows humor seems conspicuously missing.) Those interested in the dynamic psychology of humor, will be disappointed. Esar writes concerning the "little moron" joke series:

"These quips also dealt commonly with another specific action, one which pictured the little moron cutting himself. Did you hear about the little moron who cut off his fingers so he could write shorthand? . . . who cut off his hands so he could play the piano by ear? . . . who cut off his arms so he could wear a sleeveless sweater? . . . who cut off his left leg and left arm so he could be all right? *The popularity of these sanguinary sayings** may have been *due to the wartime atmosphere** in which they thrived, *or perhaps to the frequency of industrial accidents** which resulted from the rapid conversion of clerks and farmhands into machine workers."

The author notes and accepts the existence of "the Freudian slip," but he thinks many a slip isn't. He seems to have read, but to have rejected, some of the psychoanalytic writings on his general subject.

The Far Cry. By EMMA SMITH. 248 pages. Cloth. Random House. New York. 1950. Price $3.00.

The Far Cry is a story about empty people, described without ability to communicate the psychic structure. As explanation for the marriage of a beautiful girl to an English tea planter, living in a remote part of India, this "psychological" motive is adduced: "It is true to say that she married him in the end because he was sincere and she was not [p. 146]." There is also a miscarried attempt at "explaining" an adolescent girl, and an old school teacher, a blocked writer.

This Will Kill You. By CHARLES FURCOLOWE. 189 pages. Cloth. Forbes. New York. 1951. Price $2.75.

How to live longer and be healthier is a subject that concerns us all, and Charles Furcolowe has written this book, supposedly giving the answer. It is a labored attempt to make the subject funny, which, to this perhaps prejudiced reviewer, falls flat. The medical advice is, at worst, harmless and, at best, fairly sound. The author apparently knows little about psychiatry and displays strong prejudices on the subject—particularly in regard to the analytic viewpoint.

*Italics the reviewer's.

Darwin, Competition and Cooperation. By ASHLEY MONTAGU. 148 pages, with annotated bibliography and index Cloth. Schuman. New York. 1952. Price $2.50.

The human tendency to project unconsciously one's own milieu and one's own understanding of the familiar into the new and unfamiliar is an attribute of genius as well as of the common man. The savage interprets the world in terms of his own emotional, familial and tribal setting. So the towering intellect of Charles Darwin interpreted nature, to quote Professor Montagu, "in terms of the struggle for existence of men living or attempting to live in a ruthless industrial society in which the fittest alone survived." And Darwin's interpretation of evolution was used to justify further ruthlessness—and the further ruthlessness cited as proof of the correctness of the theory.

Montagu sees between Darwin and Victorian industrial society the same relationship which, this reviewer would note, was later to be demonstrated between Westermarck and Victorian sexual morality, with the natural history of man's sexual behavior interpreted in terms of Victorian repression and the interpretation used in turn to justify the repression. As a wider knowledge of anthropology and zoology has demolished the case for Westermarck, so wider knowledge of anthropology, zoology, biology and ecology has modified the concepts of Darwin. The general facts and conclusions of his mighty work stand, but conclusions about evolutionary mechanisms and their relative importance have been altered greatly.

Darwin, in the view of many modern biologists, vastly overestimated the role of competition in survival and vastly underrated the role of co-operation. From the simple multicellular organism to the mammalian species and to human society, there must be co-operation (of cells or of social organisms) to survive. Montague thinks, and cites a long list of modern authorities who agree with him, that this essential co-operation, rather than the destructive competition envisaged by Darwin, is the factor to be emphasized in the evolutionary process. The conclusion is based on evidence, some of which may be held to have been improperly evaluated by Darwin, or which was altogether unavailable to Darwin. For instance, Darwin assumed as a self-evident truth that there were superior and inferior human races; and it would be difficult to find a single modern anthropologist who would agree with him, for the entire evidence of research since Darwin's day is to the contrary.

Montagu's aim in this volume is to present the modern views of evolution noted here, and to counteract, insofar as possible, some of Darwin's emphasis on ruthless competition which is sometimes cited as scientific justification for human cruelties and human aggression. Although he has not so presented it, he has also—as has been noted—given a remarkable picture, of vast psychiatric interest, of the tendency of even the commanding

intellect to project its own emotions and social setting into the methods and results of scientific research. For a pertinent psychoanalytic note on motivations of attitudes toward the theory of the struggle for existence, Montagu quotes R. E. Money-Kyrle to show the role of defenses against unconscious guilt.

This reviewer thinks this volume should be stimulating reading to any scientist, informative to any intelligent, well-read person, and invaluable as background material for any worker dealing with individual or group aggression. How far all of Montagu's views are accepted by fellow-anthropologists might be difficult for an outsider to the discipline to estimate—as well as the extent of the influence of his own social and personal frame of reference on his findings. But Montagu's modern view is certainly shared by large numbers, if not by a majority, of workers in his field; and the present short study is ably documented by numerous pertinent and lucid quotations. The extensive annotated bibliography cites many others who share this point of view.

Montagu quotes Dobzhansky to the effect that "Cooperation, competition, struggle . . . may, under various circumstances and at different times" contribute to a species' survival and that, "Whether cooperation or disoperation prevails at a given time in a given environment depends upon the adaptive exigencies of the situation." For himself, he concludes:

"There can be little doubt that the adaptive exigencies of man's situation in the world today make it abundantly clear that if he is to survive he must cease to compete disoperatively and begin, with greater awareness than he has in the past, to co-operate." This is a conclusion to which one thinks any social scientist can well add, "amen."

The Kind and the Foolish. By LAURENCE HOUSMAN. 239 pages. Cloth. British Book Centre. New York. 1952. Price $2.75.

These short tales remind the reader very much of William Butler Yeats, with certain rather noticeable variations. While Yeats emphasized the mythology of Ireland and had as his models the pagan deities, Housman has refrained for the most part from localizing his themes and has adopted a Christian viewpoint. Most readers will find enjoyment in reading one or two of these short "fairy tales," but this is a difficult book to take at one sitting. The stories, while interesting in themselves, are too much alike.

I Can't Sleep. By GEORGE W. MORRISON. 81 pages. Cloth. Thomas Y. Crowell Company. New York. 1948. Price $1.50.

This is a book dedicated to the insomniac. It has 54 time-tested theories on sleep that are silly, scientifically unsound, and guaranteed to produce sleep for no one. However, they are hilariously funny; they provide an hour of relaxation and laughter, and might be just the thing you need before you go to bed at night.

The Pillar of Fire. By KARL STERN. 302 pages. Cloth. Harcourt, Brace & Co. New York. 1951. Price $3.50.

Epistle to an Apostate. By BERNARD HELLER. 104 pages. Cloth. The Bookman's Press, Inc. New York. 1951. Price $2.00.

These books are being reviewed together because the *Epistle to An Apostate* is a critique of *The Pillar of Fire.*

The Pillar of Fire is an autobiography of an Odyssey in the realm of religion written by a psychiatrist. The book is well written and interesting. The author's experiences, except those in religion, were not unusual for a person who experienced the ideological turmoil which produced a Hitler. The best parts of the book relate to the religious philosophies which confused the author and finally converted him from Judaism to Catholicism. Dr. Stern does not claim that he knows the exact reasons for his conversion except that Catholicism seemed best to satisfy his religious ideals. It is true that he gives explanations, but they are not unequivocal or clear cut.

It is not difficult to imagine a Jewish boy whose father and mother are not orthodox or even strongly religious; a boy who is allowed to know other religions than his own; a boy, or young man, who meets and who is friendly with and gets to admire persons of other faiths; a young man who is not sure as to what his religious faith really is. It is not difficult to imagine this young man picking a bit of religious philosophy here and a bit there. It is not difficult to imagine him bargaining in the temples of the gods until, finally, he finds a manifest religion which seems to satisfy his emotional needs. This may be the honest way to find the religion of one's desire. Who knows? Who can sincerely criticize him?

But there are critics who will thoroughly condemn Dr. Stern's change in religious viewpoints. One of these critics is Dr. Heller, author of *Epistle to An Apostate.* Dr. Heller cannot possibly imagine a Jew becoming a Catholic. He asserts that Dr. Stern is not even correctly informed regarding the history, the ritual and the holy days and customs of Judaism. Dr. Heller states: "*The Pillar of Fire* by Karl Stern, whose thesis I have weighed and found wanting, appears to me as weeds which were allowed to sprout by our neglect to spread the knowledge of Judaism to Jews. . . . While one may condone your incorrect and inexact description of Jewish practices, your version or rather perversion of Judaism's classic affirmations and attitudes are inexcusable. They reveal not only ignorance but a disposition to distort facts which is distressing. . . . *The Pillar of Fire* is more than a record of an individual's religious views and vagaries. It is intended as a missionary tract. . . ."

Dr. Heller expresses his criticism very frankly and, in places, bitterly. In his preface he even criticizes the publishers for printing the book. The

reviewer wondered why, then noted on the book jacket the following: ". . . The Roman Church has stepped up its campaign to induce Jews to adopt the Catholic religion. Tracts are written specifically for Jews and a series of articles and books have been published narrating 'The Pilgrimage from the Synagogue to the Church' by Jewish converts. . . ."

Time's Corner. By NANCY WILSON ROSS. 310 pages. Cloth. Random House. New York. 1952. Price $3.50.

Miss Ross specializes in fictionalized confusion: Her preceding book, *I, My Ancester,* was characterized in a review in these pages as "confused and confusing"; the present volume continues in the same vein. The heroine seeks, after an unhappy love affair, "peace of mind" in an Anglican House of Retreat; a drug addict in the form of an adolescent delinquent girl is smuggled by her gangster friend into the Retreat; the lady-guest gets involved with a "diabolical" doctor who treats the girl, and at the same time convinces the lady that she herself should become an addict under the guise of scientific experiments. To make matters more alluring, the blasphemous proposal to "explain" religious phenomena via drugs is put in operation. Finally, *deus ex machina,* in the form of the doctor's crippled brother-in-law, solves the problem by forcing the heroine to stop.

This story suggests that some writers should avoid literary contact with physicians—it only confuses them, and progressively to boot. In *I, My Ancestor,* there was only a mystically-circumlocutory psychiatrist, conveniently drowned before treatment ended: in *Time's Corner* the physician deteriorates mentally, and is half- or three-quarters schizophrenic. The psychological reactions of the people in the book are neither explained nor motivated. The entire well-written confusion (intermingled with naïve descriptions of the mental results of an unidentified drug) is dedicated to the author's editor, who obviously encouraged the whole nonsense. The title of the book would be better, not as *Time's Corner,* but as *Confusion's Corner.*

The Well-Adjusted Personality. Preventive Psychiatry for Everyday Use. By PHILLIP POLATIN, M. D., and ELLEN C. PHILTINE. 262 pages. Cloth. Lippincott. Philadelphia. 1952. Price $3.95.

The authors, a husband and wife combination, have added another pleasantly-written, non-technical book to the layman's library. In a few places the authors write of psychoanalytic theories, but not extensively. They suggest that one should stop worrying about the frustrations which were developed in childhood and start readjusting what he has now. "Adults who reach maturity with some troublesome emotional patterns uncorrected in childhood are past the hope of avoiding problems, it is assumed. If this fatalistic assumption were true, most of us would be condemned to serious

unhappiness, for few have had so ideal an upbringing as to avoid all emotional quirks and maladjustments. It is the object of this book to demonstrate how preventive psychiatry applies to adults and how it can be utilized as a bridge to happier, more satisfying living, even if some emotional problems do exist. . . . the prevention of emotional difficulties can be achieved by attention to the present emotional environment which can be manipulated and changed according to the individual need, provided we ourselves and those about us understand what those needs are. We have to work toward some understanding of our own emotional resources and limitations, not with a view toward avoiding all responsibility to society and its self-preservative demands for conformity, but rather with the object of discovering what maximum conformity we are capable of that will benefit society and yet preserve ourselves."

In this vein of thought the authors discuss the problems of students, of marriage, of parents and, finally, the problems developing during the change in productive life and the advanced years.

How to Use Hypnosis. By Dr. David F. Tracy. 158 pages plus index. Cloth. Sterling Publishing Co., Inc. New York. 1952. Price $2.50.

This volume is a brief, superficial discussion of hypnosis, how it may be induced, and its uses, both practical and exhibitory. No explanation of the theories involved, or of the pitfalls which may be encountered, is given. The reader is promised rich rewards if he includes hypnotism among his accomplishments, as, it is claimed, it will develop in him a more dynamic and forceful personality.

The book offers little that is new to physicians.

Life Is with People. By Mark Zborowski and Elizabeth Herzog. 430 pages plus appendix. Cloth. International Universities Press. New York. 1952. Price $5.00.

Mark Zborowski and Elizabeth Herzog have mixed the findings of a group working in the Columbia University Research on Contemporary Culture with warmth, sympathy, and understanding derived from personal experience and background, producing an account of the Eastern European Jewish community that is both scientifically accurate and makes exceptionally good reading. It is a happy book, this, and obviously a labor of love, for the whole is seen through a golden haze of childhood memories that bathe the scene in nostalgia and gentle regret, which in no way detracts from the accuracy of the data presented.

It is the story of the *Shtetl,* the "Jewish Little Town," and a way of living that is no more. The strength and beauty of a community united in work and religion is shown—from the relative aristocracy of the *sheyneh*

yidn to the lower masses of the *prasteh yidn*. Each aspect of the whole of life is examined, and the twin sayings, "It is good to be a Jew," and, "It is hard to be a Jew," are confirmed and corroborated.

A foreward by Margaret Mead and a glossary of Yiddish terms are included in a book which is to be highly recommended for all who are interested in their fellowman.

None but My Foe. By DAVID DUNCAN. 232 pages. Macmillan. New York. 1950. Price $3.00.

The author, a "popular contributor to *Collier's*," makes an unsuccessful excursion into depth psychology. Without the slightest understanding, he depicts a paranoiac writer, embittered over the death of his wife, a tragedy he attributes to the "stupidity" of the mayor of a small town. To take revenge on the malefactor, an allegation of poisoning of the water reservoir is manufactured. The revenge plan miscarries, but not before mass hysteria and mob rule are established. The far-fetched plot is senselessly "explained": The husband hated his wife—consciously—for he did not want "to increase a debt of gratitude," incurred because she made his life more comfortable. To top all the errors in evaluation of motivations and characters, the author tells also (through his hero, Stephen) about his opinions of modern psychiatry: "As far as I'm concerned, psychiatry, for a writer's purposes, can be chucked in the ash can." The author even elaborates further: "Modern psychiatry has gotten itself stuck in everybody's hair like so many pieces of flypaper. . . . It's particularly hard on writers, because if we ignore it, we're out of step; and if we use it, we're hog-tied." (P. 51.) What Mr. Duncan overlooks, is the third possibility: that the writer *intuitively* may let his *dramatis personae* act psychologically correctly. This, however, presupposes unconscious perception, a trait this author sorely lacks.

Appraising Personality. By MOLLY HARROWER, Ph.D. xvii and 196 pages. Cloth. Norton. New York. 1952. Price $4.00.

While designed for the general practitioner, this book will find a useful place as an aid to many in fields related to psychiatry. The tests and techniques of clinical psychology are explained and their areas of usefulness shown. The writing technique in this book, which is a hypothetical conversation between a general practitioner and a clinical psychologist, is awkward at times, but for the most part the treatment is comprehensible and informative. While the meanings behind responses to certain tests are indicated, there is no intent to go deeply enough into the scoring for practical application. Substitute test plates, rather than the originals, are used to illustrate such tests as the Rorschach and the Szondi.

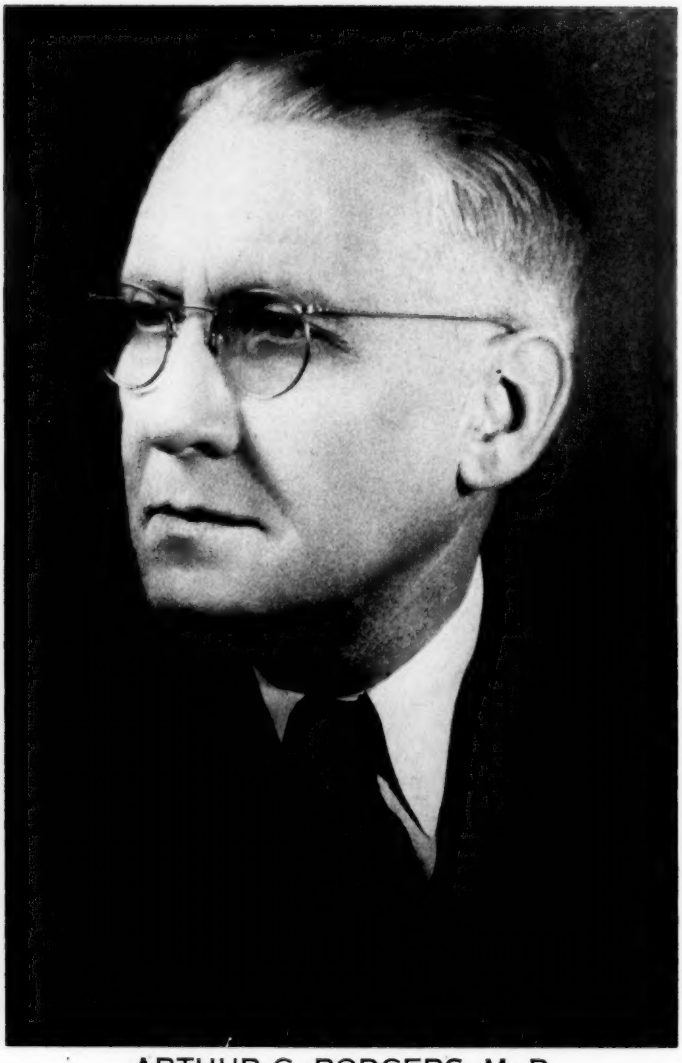
RICHARD F. BINZLEY, M. D.

Dr. Richard F. Binzley was appointed director of Syracuse Psychopathic Hospital, November 1, 1952, by Commissioner Newton Bigelow, M. D., of the New York State Department of Mental Hygiene. He succeeded Nathan Beckenstein, M. D., transferred to Brooklyn State Hospital as director to succeed the late Dr. Clarence H. Bellinger.

Dr. Binzley was associate director of Pilgrim State Hospital when he was promoted to head the Syracuse institution. Born in New Brighton, Pa., in 1903, he was graduated from Geneva College in Beaver Falls, Pa., in 1926 and from the school of medicine of Western Reserve University, Cleveland, in 1930. He served an internship and residency at Grasslands Hospital, Valhalla, N. Y., then entered the service of the New York State Department of Mental Hygiene at Pilgrim in 1933. He had been associate director at Pilgrim since 1951.

Dr. Binzley holds certificates in both psychiatry and neurology from the American Board of Psychiatry and Neurology. He is a member of the American Psychiatric Association and other professional organizations. Dr. Binzley is married to Dr. Constance Barwise, also a psychiatrist. They have one son, Richard Charles Binzley, now 15 years old.

RICHARD F. BINZLEY, M. D.



ARTHUR G. RODGERS, M. D.

ARTHUR G. RODGERS, M. D.

Arthur G. Rodgers, M. D., assistant director of Central Islip State Hospital, was appointed director of Binghamton State Hospital on January 1, 1953, by New York State Commissioner of Mental Hygiene Newton Bigelow, M. D. He succeeded Dr. Hugh S. Gregory, retiring director of the Binghamton hospital.

Dr. Rodgers has been in the state service for some thirty years and had served at Central Islip since 1931. He was assistant director there when he was promoted to the position at Binghamton. Born in Watervliet, N. Y., in 1892, Dr. Rodgers was graduated from Albany Medical College in 1915. After internship at Troy (now St. Mary's) Hospital, Troy, N. Y., he joined the staff of Willard State Hospital and a year later was transferred to Hudson River State Hospital. Early in 1918, he became a captain in the Medical Corps of the United States Army and served in France and Belgium, attached to a British division, and later with the Army of Occupation in Germany.

After World War I, he was in private practice in Troy for a time and, in 1921, entered the Veterans Administration and served in Philadelphia and New York City hospitals before returning to the state service at Hudson River State Hospital two years later. He remained at Hudson River until going to Central Islip in 1931.

Dr. Rodgers is a diplomate in psychiatry of the American Board of Psychiatry and Neurology, is a fellow of the American Psychiatric Association, and of the American Geriatrics Society, and is a member of other professional organizations. He is married to the former Diana Lewis of Scranton, Pa.

CONTRIBUTORS TO THIS ISSUE

AVRAAM T. KAZAN, M. D. Dr. Kazan received his medical degree in 1938 from the College of Physicians and Surgeons, Columbia University. After approximately a year of psychiatry at Rockland State Hospital and a year and a half of neurological residency at Mt. Sinai Hospital, New York City, he went into military service. For three and one-half years he was assigned to the Air Force, Zone of Interior, doing work both in clinics and at administrative levels. He held a two-year fellowship in child psychiatry under the United States Public Health Service, and studied during this time in Louisville, Ky. Since 1948 he has been director of the division of mental hygiene of the Westchester County (N. Y.) Department of Health. The main stress of work within the division has been clinical, but considerable work has been done to date with public health nurses, both in service to them and in research around the complex subject of teaching mental hygiene.

ELLEN KRIEGER OSTROW, M. S. S. Mrs. Ostrow was mental health consultant for the Westchester County public health nurse educational program which is the subject of the article, of which she is co-author, in this issue of THE PSYCHIATRIC QUARTERLY SUPPLEMENT. A graduate of the University of Pittsburgh and of the Smith College School of Social Work, Mrs. Ostrow has been a case worker with the Jewish Family Service in New York City and a case work supervisor with the Travelers Aid Society. She was director of settlement service for the United Service for New Americans before undertaking the Westchester County project. At present she is with the Arthritis, Rheumatism Foundation.

RUTH CUMINGS, M. A. Mrs. Cumings received her B. S. in Public Health in 1944; her M. A. in Mental Health in 1950. Mrs. Cumings was the public health nurse consultant for the Westchester County educational program which is the subject of the article in this issue of THE PSYCHIATRIC QUARTERLY SUPPLEMENT. She is working with Dr. Milton V. Kline at present on a further study intended to give a clearer picture of the "public health nurse."

MILTON V. KLINE, Ed.D. Dr. Kline is psychologist of the division of mental hygiene of the Westchester County (N. Y.) Department of Health. He is a member of the department of psychology of Long Island University.

is consultant in clinical psychology at the Westchester Psychological Service Center, and is editor of *The Bulletin* of the Society for Clinical and Experimental Hypnosis.

Dr. Kline was responsible for the statistical presentation of the Westchester County public health nurse educational program which is the subject of an article in this issue of THE PSYCHIATRIC QUARTERLY SUPPLEMENT. With Mrs. Ellen Ostrow, who was social work consultant for the project, he is now engaged in a further study designed to give a clearer picture of the "public health nurse." They are studying such aspects as intellectual capacities, an inventory of mental hygiene knowledge, and personal and social attitudes.

MURRAY BERGMAN, M. D. Dr. Murray Bergman is assistant director of Newark (N. Y.) State School. He joined the New York State hospital system in 1928 and for many years served in various capacities at Middletown State Homeopathic Hospital. From 1942 to 1946 he was consulting neuropsychiatrist to the Hampton Roads Port of Embarkation and the Fort Monroe Station Hospital and, at the same time, chief of the neuropsychiatric section of the Kecoughton Station Hospital. He has specialized in many phases of psychiatry and he has written scientific papers on psychiatric subjects for publication. He is a diplomate of the American Board of Neurology and Psychiatry and his society affiliations include membership in the American Psychiatric Association, the Finger Lakes Neuropsychiatric Society and the American Association on Mental Deficiency.

LOUISE A. FISHER, A. B. Louise A. Fisher is a native of Philadelphia, Pa., and a graduate of Temple University, where she received her A. B. degree in psychology. She served as assistant psychologist at the Newark (N. Y.) State School until September 25, 1951. At present, she is engaged in advanced studies in psychology at Pennsylvania State University.

GEORGE DEVEREUX, Ph.D. Dr. Devereux is director of research of Winter Veterans Administration Hospital, Topeka, Kas., and lecturer in the Topeka Institute for Psychoanalysis and the Menninger School of Psychiatry. He is a graduate of the University of Paris, the French School of Oriental Languages, the University of California and the Topeka Institute for Psychoanalysis. He has had fellowships and grants from the Rockefeller Foundation, Harvard University, the Social Science Research Council and the Viking Fund. He is a fellow of the American Anthropological Association, a member of the American Ethnological Society and an associate member of the Topeka Psychoanalytic Society.

Dr. Devereux has done anthropological field work among the Hopi, Mohave, Yuma and Cocopa Indians; the Karuama Pygmies and the Roro of Papua, New Guinea; and the Moi of French Indo-China, and has worked in clinical setting with psychiatric patients belonging to various Indian tribes. He has published about 85 papers, a book, *Reality and Dream, the Psychotherapy of a Plains Indian;* is co-author, with Dr. Karl Menninger, of the bibliographic study, *A Guide to Psychiatric Books;* and edited the anthology, *Psychoanalysis and the Occult.*

EDMUND BERGLER, M. D. Dr. Bergler is a psychoanalyst in private practice in New York City. He has written widely on psychoanalytic subjects for both professional and general reading. He is widely known in European, as well as American, scientific circles; a graduate in medicine of the University of Vienna, he was formerly assistant director of the psychoanalytic clinic in that city. He is a frequent contributor to THE PSYCHIATRIC QUARTERLY and THE PSYCHIATRIC QUARTERLY SUPPLEMENT and is the author of well over 100 published books and scientific articles.

NED CHAPIN. Ned Chapin is a Chicago consultant to industry, specializing in personnel selection and evaluation. He holds a master's degree (1949) from the University of Chicago.

G. M. DAVIDSON, M. D. Dr. Davidson is a graduate in medicine of the University of Kazan, Russia, in 1916. After service in the Imperial Russian Army in World War I, he engaged in the private practice of medicine in the United States until 1929, when he joined the staff of Manhattan (N. Y.) State Hospital, where he is now a supervising psychiatrist. Dr. Davidson is a diplomate of the American Board of Psychiatry and Neurology and is a lecturer in psychiatry at Hunter College, New York City. He has engaged in psychiatric study and research for many years and is the author of numerous scientific reports, published in this and other scientific journals.

JOHN H. TRAVIS, M. D. Dr. Travis entered the New York State Hospital System on August 16, 1922 at Buffalo State Hospital. He has served as clinical director and first assistant physician of Creedmoor State Hospital, superintendent of Willard State Hospital and director of Manhattan State Hospital. He is now director at Manhattan.

GERDA WILLNER, M. D. Dr. Willner is a graduate of the University of Vienna in 1936. She served a rotating internship in various hospitals in Vienna and came to this country in 1938, when she again served an internship in a general hospital in Wisconsin. She went to the Central Islip

(N. Y.) State Hospital in 1943 and is at present a supervising psychiatrist there. She is a member of the American Psychiatric Association and other professional societies and is a diplomate in psychiatry of the American Board of Psychiatry and Neurology.

BENJAMIN J. HILL, Ed.D. Dr. Hill was appointed director of the Annex of State Training Schools for Boys at New Hampton, N. Y., on September 16, 1946, becoming, incidentally, the first employee of the Annex. He had been in the field of public education for 12 years as teacher and administrator. He had taught in the public schools of Sudbury, Lexington, and Needham, Mass.

Dr. Hill received his bachelor's degree in education from the State Teachers College, Bridgewater, Mass., and a master's degree from the School of Education, Boston University. He came to New York State in 1937 to teach in the Horace Mann School of Teachers College. While at Horace Mann, he studied to become a curriculum specialist in elementary education, and he received the degree of doctor of education from Teachers College, Columbia University, in 1942.

Dr. Hill spent three years in the navy during World War II, stationed on an aircraft carrier assigned to the Pacific. He was director of the American Junior Red Cross for the North Atlantic area for a year after release from active duty by the navy. At present, he is educational advisory officer of the United States Naval Reserve Unit in Newburgh, N. Y.

E. R. CLARDY, M. D. Dr. Clardy received his medical degree from the University of Tennessee College of Medicine in 1929, serving a rotating internship in Jacksonville, Fla., then interning in psychiatry at Brooklyn State Hospital. He was instructor in neuropsychiatry at the University of Tennessee College of Medicine from 1932 to 1934. He entered New York State service at Rockland State Hospital in 1934 and began child guidance work in Rockland and Westchester counties that same year. He began work in child psychiatry when the Rockland State Hospital's Children's Group was opened in 1936; he was placed in charge of the Children's Group in 1939, and holds that position at present, with the title of supervising psychiatrist. He is the author of a number of scientific articles on schizophrenia and behavior disorders in childhood, and has contributed previously to THE PSYCHIATRIC QUARTERLY and THE PSYCHIATRIC QUARTERLY SUPPLEMENT. He was a member of Governor Dewey's Citizen's Committee on Children to determine needs and facilities for the care and treatment of children in New York State and was a member of the Mid-century White House Conference on Children in 1950. Dr. Clardy is attending psychiatrist at the Annex of State Training Schools for Boys at New Hampton, N. Y.

NEWS AND COMMENT

DR. BECKENSTEIN BECOMES NEW DIRECTOR AT BROOKLYN

Nathan Beckenstein, M. D., director of Syracuse (N. Y.) Psychopathic Hospital since 1950, was transferred on November 1, 1952, to become director of Brooklyn State Hospital, the institution where he had spent 18 of the 25 years of his professional career.

Born in Brooklyn in 1904 and a graduate of Cornell University Medical College in 1928. Dr. Beckenstein interned at Jewish Hospital, Brooklyn, and at Binghamton State Hospital before joining the Brooklyn State Hospital staff in 1929. He became assistant director there in 1941, serving under the late Dr. Clarence H. Bellinger, whom he now succeeds as director. In 1947, Dr. Beckenstein was appointed acting medical inspector for the New York State Department of Mental Hygiene and in 1950 was named to head the Syracuse hospital, serving also as assistant commissioner of mental hygiene until early in 1952.

Dr. Beckenstein returns to a locality where he had long been active in community affairs. He is a member of the board of trustees of the Grand Street Settlement House, and is a trustee of the Brownsville-East New York YMHA and YWHA. He is a diplomate of the American Board of Psychiatry and Neurology, a fellow of the American Psychiatric Association and a member of other professional societies.

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HARRIET BABCOCK, Ph.D., DIES AT 75

Harriet Babcock, Ph.D., widely known as a clinical psychologist and writer on psychological subjects, and a specialist in the measurement of the efficiency of mental functioning, died on February 18, 1953, at her home in New York City at the age of 75.

Dr. Babcock served as psychologist at Manhattan (N. Y.) State Hospital in 1924 and 1925, as chief psychologist at Bellevue from 1926 to 1928, and had engaged in research for more than 20 years before her death. Born in Rhode Island and a graduate of the Rhode Island Normal School, she taught school in that state before coming to New York to study psychology at Columbia University, where she received a bachelor's, a master's and a doctor's degree in that subject.

She was the author of four scientific books, dealing with her research specialty and presenting her results and conclusions, *An Experiment in the Measurement of Mental Deterioration; Dementia Præcox, a Psychological Study; Revised Examination for the Measurement of Efficiency of Mental Functioning;* and *Time and the Mind.* She also contributed a number of

articles to psychological and other scientific and technical journals. She was a fellow of the American Association for Applied Psychology, and a member of the New York Academy of Sciences, the American Psychological Association and other professional societies. Dr. Babcock was the widow of H. Hobart Babcock.

GROUP DEVELOPMENT LABORATORY TO HOLD SESSION

The National Training Laboratory in Group Development has announced its annual three-week session will be conducted for 1953 from June 21 through July 11 at Gould Academy, Bethel, Me. The laboratory will accept about 110 applications for the session from persons in any field involving working with groups in training, consultant and leadership capacity. Role-playing and observer techniques are employed for the practice of group skills of analysis and leadership. Application of the laboratory work to the students' jobs at home will be discussed during the last week of the session. The annual laboratory meetings are sponsored by the division of adult education service of the National Education Association and by the University of Michigan.

WORLD MENTAL HEALTH CONGRESS TO BE IN CANADA

The World Federation of Mental Health will conduct the Fifth International Congress on Mental Health at the University of Toronto, Canada, from August 14 to 21, 1954, at the invitation of the Canadian Mental Health Association and the Canadian Psychological Association. The general theme is to be: Mental Health in Public Affairs.

The previous congresses were conducted in 1930, 1937, 1948 and 1951 in Washington, Paris, London and Mexico City. The membership of the World Federation of Mental Health is made up of mental health associations and professional societies in all the major fields concerned with mental health.

SHAFFER BECOMES HEAD OF PSYCHOLOGICAL ASSOCIATION

Dr. Lawrence F. Shaffer of Teachers College, Columbia University, became president of the American Psychological Association at its sixtieth annual convention in Washington in September. Dr. O. Hobart Mowrer of the University of Illinois was named president-elect.

More than 5,000 psychologists, or about half the national membership of the association, attended the session. A code of ethics, in preparation for four years, was adopted by the association. It is intended to protect the public against fraudulent practice and to set standards of conduct and responsibility for the psychologists themselves.

HUGH S. GREGORY, M. D., BINGHAMTON DIRECTOR, RETIRES

Dr. Hugh S. Gregory, head of Binghamton State Hospital since 1942, retired as director of that institution on January 1, 1953 after 40 years in the New York State service. Dr. Gregory had spent the greater part of his career at the Binghamton hospital.

Graduated from Albany Medical College in 1913, Dr. Gregory became an intern at St. Lawrence State Hospital a short time later and was senior assistant physician there when he was transferred to pathologist at Craig Colony in 1918. He became senior assistant physician at Binghamton in 1920 and a few months later was named pathologist at that hospital. He became superintendent of Newark State School in 1930 but returned to his pathology work at Binghamton in 1931. Transferred to Creedmoor State Hospital as first assistant physician in 1938, he returned to Binghamton as superintendent in 1942 and continued to head that institution until his retirement.

Dr. Gregory is a life member of the American Psychiatric Association and of numerous other professional and civic organizations. He has been active for many years in the civic life of Binghamton and is living there with Mrs. Gregory following his retirement. A son, Howard P. Gregory, also lives in Binghamton. A second son, Captain Robert S. Gregory, was killed in France during World War II.

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CLINIC DIRECTORY AND TREATMENT GUIDE ARE ISSUED

A directory of all psychiatric clinics now operating in New York State has been published by the New York State Mental Health Commission. It contains information concerning private, as well as state and other public, treatment facilities, compiled as a result of a survey undertaken during the summer of 1952. Twenty-seven of the community clinics listed came into existence during the last three years, with the aid of the Mental Health Commission. The new directories are being supplied to schools, hospitals, welfare agencies and other possible referring sources.

A guide, *Residential Treatment Centers for Emotionally Disturbed Children*, covering a number of both public and private institutions throughout the country, has been issued by the Children's Bureau of the Federal Security Agency, and is intended primarily for the use of child care agencies, child guidance clinics, psychiatrists and other physicians. Mental hospitals and state training schools are not listed; but the booklet covers a variety of other institutions from coast to coast, with notes on admission policies, plant, staff, and charges where service is not free. Copies of the bulletin may be obtained from the superintendent of documents, Government Printing Office, at 25 cents each.

ROCKMORE NAMED TO GROUP STUDYING RELEASE PROGRAM

Myron J. Rockmore, psychiatric social worker, has been named to assist Dr. Daniel Blain and Attorney Robert J. Feldman in the study being made for the New York State Mental Hygiene Council of procedures employed in New York and other states in the release of mental patients from institutions. The council is headed by the Honorable Charles L. DeAngelis of Utica, and Dr. Blain, in serving as psychiatrist in charge of the study of releases, is acting in his private capacity, not as an officer of the American Psychiatric Association, of which he is medical director.

Mr. Rockmore is a graduate of St. John's College, Brooklyn, has a master's degree from St. Lawrence University, and holds a diploma from the New York School of Social Work. He has been in psychiatric social work since 1938, including army service as chief military psychiatric social worker at a number of army posts. He is at present director of social service at the treatment center of the New York Psychoanalytic Institute.

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CARMICHAEL HEADS GROUP PSYCHOTHERAPY ASSOCIATION

Donald M. Carmichael, M. D., associate director of Rockland State Hospital and acting medical inspector for the New York State Department of Mental Hygiene, was elected president of the American Group Psychotherapy Association at its tenth annual conference in New York City on January 9 and 10. The conference discussed, among other subjects, alcoholism and addiction, and problems of the aged.

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McCARTHY NAMED DIRECTOR OF ALCOHOLISM RESEARCH

Raymond G. McCarthy, executive director of the Yale Plan Clinic, has been appointed director of alcoholism research for the New York State Mental Health Commission, it has been announced by Commissioner Newton Bigelow, M. D., of the Department of Mental Hygiene, chairman of the commission. Mr. McCarthy has been executive director of the Yale clinic since 1944. He has also been serving as educational director of the Connecticut Commission on Alcoholism and is the author of a number of books on the alcohol problem.

Concerning the same problem, the commission has made grants of two funds for community services for chronic alcoholics, one to the University of Buffalo Information and Rehabilitation Center for Alcoholism and another to a new clinic to be operated by the Syracuse Dispensary, Inc. The eight-man advisory commission named to aid the Mental Health Commission in establishing a program on alcoholism conducted its first meeting in Albany last October.

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